MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH ond 2 OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death by the funeral Bages 1 and 2 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence befare admission) o. STATE o. COUNTY Anne Arundel 5. COUNTY New York MARYLAND Queens b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn)

LOTNIAN c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN Jb. New York Flushing 3 Days d. STREET ADDRESS e. IS RESIDENCE ON A FARM? physician and completely filled in d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Office of Dr. Wilson and Dr. Wirth 43-57 Union St. YES NO X corbon | Middle 4. DATE 3. NAME OF First Last Manth Year DECEASED Ader .. Sherman March 26 67 hove corb (Type or print) DEATH IF UNDER 24 HRS. IF UNDER I YEAR S. SEX 6. COLOR OR RACE B. DATE OF BIRTH 9. AGE (In years 7. MARRIED NEVER MARRIED birthday) Male White DIVORCED Aug. 31 WIDOWED 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT U.S.A during mast af warking life, even if retired) Textile New York Salesman 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME signed by the ottending physi buriol-tronsit permit. Then pl buriol, cremation, or removal, Abraham Anna J. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT Address (Yes, na, ar unknawn) (If yes give war or dotes of service Harold Ader 340 W. 28 St. Yes 1B. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH PART I DEATH WAS CAUSED BY: Acute coronary thrombosis IMMEDIATE CAUSE (a). DUE TO arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), DUE TO os the prior to l stating the underlying cause has been last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPS'
PERFORMED? 3 shauld be detached for use with the State Dept. of Health NO MA hypertensive cardiovascular disease TO HOSPITAL OR ATTENDING PHYSICIAN: Poge 4 may be retained by the hospital or TO FUNERAL DIRECTOR: After this certificate 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.) 20o. ACCIDENT WAS UNDERLYING [7] OR CONTRIBUTING CAUSE OF DEATH no accident (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year factory, street, affice blda., etc.) 3/26/67 at wark 21. I certify that (1) (A) Xoxp(v) attended the deceased from 10:00AM 2/ 40/01 2:00 nooty\_\_\_, that (I) (we) last saw the deceased alive on 3/26/67 19 , and that death occurred at 12 AM, from causes and on the date stated above. 22b. DATE SIGNED 22a. SIGNATURE ATTENDING STAFF PHYS. 3/26/67 DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S Lothian, Maryland, 20820 NAME (Type) Charles Wirth. 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, 23b. DATE THEREOF (County) (State) REMOVAL (Specify) Flushing NY Hebron 1010 2Sq. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 74 "FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 Ocharles Judge

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THE PARTY OF THE P 20080 CARL TO TAKE 

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03006 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 haurs after death funeral 1 apd PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY completely filled in by the fur love carban papers. Pages 1 y event, within 72 haurs after, MARYLAND b. CITY OR TOWN (If autside carparate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) write RURAL and give nearest town) YRS. BoltIMORE 6 Lon Burne R d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Langhet Road YES NO K NAME OF Middle First 4. DATE Month Day Year DECEASED 8. ASHMENSKAS OF GEORGE 26-1967 (Type or print DEATH S. SEX IF UNDER 24 HRS. 6. COLOR OR RACE 8. DATE OF BIRTH (1891) 9. AGE (In years IF UNDER 1 YEAR 7. MARRIED NEVER MARRIED lost birthday) Months Dovs Haurs remov and in any WIDOWED 📈 DIVORCED 10a USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? boturn MD. RR Lith. Reterred -USA. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME removal attending phys UN KNOWN Unknown 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address permit. (Yes, no, or unknown) I(If yes give war ar dates of service Ġ 922 hong bey Rd -MRS, MORIE Kucher-NO trematian, 18. CAUSE OF DEATH (Enter only one couse per line for (g), (b), and (c).
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN signed by the burial-transit p ONSET AND DEATH IMMEDIATE CAUSE (a) by the haspital ar attending physician. DUE TO Conditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying couse ue aerached far use as the State Dept. of Health priar ta last PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY has PERFORMED? NO YES certificate PHYSICIAN: 20g. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED (City or town) 20c, TIME OF INJURY Manth, Day, Year 20e. PLACE OF INJURY (Home, form, (County) (State) Hour o.m. Not While factory, street, office bldg., etc.) of wark at wark 21. I certify that (1) (this hospital) attended the deceased from Bushand , 1965, to march , 19 67 that (1) (we) last saw the deceased alive on. 19 67, and that death accurred at M. fram causes and on the date stated above. 22a. SIGNATURE 22b. DATE SIGNED DIRECTOR M.D. director, page shauld be filed 22c. PHYSICIAN'S 22d. ADDRESS O HOSPITAL FUNERAL NAME (Type) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23a. BURIAL, CREMATION (County) (State) REMOVAL (Specify) Holy Coss Cometery Brootly 9 Burial. 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR Melanles John H Hahn Foral Home 1200 Bennyton Ave

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## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| DEALID  | DETI.                                  |               | PLACE OF DEATH  |                               |                            |  | (Where deceased lived, if institution; F  | Residence before admission)   |
|---|--|---------------|---|-------------------------------|----------------------------|--|---|-------------------------------|
| ay is<br>3 ta<br>Page                           | of                                     |               | o. COUNTY Anne  | Arundel                       | MARYLAND                   | 0. STATE Mary  | land b. COUNTY A                          | nne Arundel                   |
| delay<br>and 3<br>A3. Pa                        | ent                                    |               | o. CITY OR TOWN (If outsid<br>write RURAL and give n      | e corporate limits,           | c. LENGTH OF STAY IN 16    | c. CITY OR TOWN (If o                                | outside corporate limits, write RURAL a   | and give nearest town)        |
| y del<br>ond<br>PM3.                            | T L                                    |               | Gken Bu   | rnie                          | 11111                      | Ritchie  | Hgts, Pasadena                            | 02.1                          |
| 2 2   | ebo                                    |               |   | NSTITUTION (If not in hospite | ol, give street oddress)   | d. STREET ADDRESS                                    |   | e. IS RESIDENCE<br>ON A FARM? |
| es 1,<br>farm                                   | State Department of                    |               | North Aruno   | del Hospital                  |                            | Route 9  | ), Box 342                                | YES NO W                      |
| death. It<br>e Pages<br>with far                |  |               | NAME OF   | First                         | Middle                     | Losi   | 4. DATE Month                             | Doy Year                      |
| 0 0 >   | 2                                      |               | DECEASED<br>Type or print)                                | WALTER                        | В                          | CKETT  | OF March 24                               | 1967                          |
| after<br>8. Give<br>alang                       | (#I )                                  | 5,            |   | OR OR RACE 7. MARRIE          | D NEVER MARRIED            | 8. DATE OF BIRTH                                     |   | UNDER I YEAR OF UNDER 24 HRS. |
| 18  | 12 m                                   |               |   | nite WIDOW                    |                            | Jan. 12.18   | AB 79 yrs.                                |                               |
| haurs<br>Item 1<br>Office                       | and 2                                  | 10o           | USUAL OCCUPATION (Give king masket working)               | ind of work done              | KIND OF BUSINESS OR        | 11. BIRTHPLACE (State                                | e or foreign country)                     | 12 CITIZEN OF WHAT            |
| 24  | offer                                  |               |   | (Mer.)                        | dVfBson Chemi              |  | ore, Md.                                  | USATRY?                       |
| within an pencil i                              |  | 13.           | FATHER'S NAME   |                               |                            | 14. MOTHER'S MAIDEN                                  | NAME                                      |                               |
| wit   | 7. File pag                            | 10            | William   | Beckett                       |                            | Mol  | lie Berger                                |                               |
| red<br>in al                                    | ii. 1                                  |               | WAS DECEASED EVER IN U.S.<br>s, no, or unknown) (If yes g | ive wor or dotes of service)  |                            | /. INFORMANT   | Address                                   |                               |
| executed<br>inding" in<br>Medical B             | permit.<br>within 72                   |               | NO N  | one                           |                            | Mrs Louisa   | E. Beckett (wif                           |                               |
| d be executed<br>d "pending" i<br>Chief Medical | Si →                                   |               | 18. CAUSE OF DEATH (Er<br>PART I. DEATH WAS               | caused By: M1:                | for (o), (b), and (c).)    | injuries   |   | ONSET AND DEATH               |
| d be<br>d "pe<br>Chief                          | burial-tronsit<br>any event            |               | 0124 11   | MMEDIATE CAUSE (a)            | itelpie severe             | Injuries   |   |                               |
| shauld<br>word<br>a the C                       | urial-1                                |               | Conditions, if any, which                                 | DUE TO                        |                            |  |   |                               |
| W @ 5   | -                                      |               | rise to immediate couse                                   | (0), (0)                      |                            |  |   |                               |
| rate<br>ng t                                    | as a                                   |               | stoting the underlying colost.                            | ouse (c)                      |                            |  |   |                               |
| s certificate<br>e, writing th<br>farwarded to  |  |               | PART II. OTHER SIGNIFICAL                                 |                               | G TO DEATH BUT NOT RELATED | O THE TERMINAL DISEASE CO                            | NDITION GIVEN IN PART 1(a)                | 19 WAS AUTOPSY                |
| e, w  | be used<br>removal,                    | CERTIFICATION |   |                               | <u>- 33- 5 4000</u>        |  | 1-1                                       | PERFORMED? YES X NO           |
| This irate, be for                              | rem                                    | IFIC          | 200 EXTERNAL CAUSE WAS<br>PRIMAR XX or CONTRIBUT          | S 20b.                        | DESCRIBE HOW INJURY OCCURR | D. (Enter noture of injury in                        | Port I or Port II of item 18.)            | 140 (25)                      |
| Sertific Bo                                     | auld<br>ar r                           |               | PRIMARY Sor CONTRIBUT<br>CAUSE OF DEATH.                  | ING 🗆                         | Pedestrian st              |  |   |                               |
| INE<br>e ce<br>sha                              | yaur riles<br>Page 3 sho<br>cremation, | MEDICAL       | 20c. TIME OF INJURY Mon                                   | nth, Doy, Yeor 200            |                            | PLACE OF INJURY (Home, for                           | m, 20f. (City or town)                    | (County) (Stote)              |
| AM<br>e th                                      | Page                                   | MEC           | 7:10 OUK XX   |                               | rark Ot While X            | factory, street, office bldg., etc<br><b>Highway</b> | Ann                                       | eArundel Md.                  |
| FX Table  |  |               |   |                               | remains described above,   |  |   |                               |
| exe<br>or.                                      | DIRECTOR:  to burial,                  |               | death resulted fro  |                               |                            | uicide , Homicide                                    |   |                               |
| MEDI<br>please<br>direct                        | DIRECT<br>DIRECT<br>In to bur          |               | remu (2)  |                               |                            | CHIEF MEDICA   | EXAMINER                                  |                               |
|   | ar t                                   |               | SIGNATURE W   | uls J. o                      | y gal                      | THIS DO.   | DICAL EXAMINER X                          | 22. DATE SIGNED               |
| O DEPUTY<br>necessary, p                        | FUNERAL I ealth prior                  |               | EXAMINER'S Cha  | arles S. Sprí                 | ngate, M.D.                | DEPUTY MEDIC<br>Address (Street                      | AL EXAMINER<br>et, city, town, or county) | 3-25-67                       |
| O DE  | O FUNE<br>Health                       | 23o           | BURIAL, CREMATION,  | 23b. DATE THEREOF             | 23c. NAME OF CEMETERY      | *              | 23d. LOCATION (City or Town)              | (County) (Stote)              |
| 0 c ± .   | 2 ±                                    |               | REMOVAL (Specify)   | Merch 29 1                    | 976 Glen Wass              | n Mam Dank   |   |                               |
| V0 43   | SME (S)                                | 24            | FUNERAL DIRECTOR  |                               | 976 Glen Have              |  | D BY REGISTRAR 2STOPENSISTE               | AR" SIGNATURE                 |
| 6M  | 1/67 T                                 |               | Richard V.  | Singleton                     | Glen Burni                 | B. Md. MAN   | 40 1300                                   | Jan Jan                       |

10 miles 11 miles 14 13333 CATEUR TERE V 181 2 31 . C the said of the rockets(sta) greens .- gain. pin prin-15-15 - cmid 15 - Network 23,100 Time town the test that the series in the s sto est b. stoplosin the films, discorde

| /1       | Division of   | STATISTICAL I  | MARYL<br>RESEARCH A             | AND STATE DE<br>ND RECORDS, 30'          | PARTMENT OF H<br>I W. PRESTON STR                         | IEALTH<br>EET, BALTI              | MORE, MARYL              | AND 2120        | 1                 |                         |
|----------|---|----------------|---------------------------------|--|---|-----------------------------------|--------------------------|-----------------|-------------------|-------------------------|
|          | 03017   |                |                                 | CERTIFICATE                              | OF DEATH  |                                   |                          | 0.20            | 100               | ,                       |
| a.       | LACE OF DEATH COUNTY Anne Arun  | del            |                                 | MARYLAND                                 | 2. USUAL RESIDENCE<br>o. STATE<br>Mary                    | land                              | b. COUN                  | ITY             | bolore-odmis      | <b>V</b>                |
|          | CITY OR TOWN (If autside carpi<br>write RURAL and give nearest<br>Crownsvill<br>NAME OF HOSPITAL OR INSTITU | town)          | 1,                              | on. 6 das.                               | C CITY OR TOWN (If a                                      | utside carporo<br>imore           | re limits, write KUP     | KAL ond give n  | l e. ÍS RE        | SIDENCE                 |
| d.       | Crownsville S   |                |                                 | oddress/                                 |   |                                   | ne Stree                 | t               | ON A              | FARM?                   |
| (T       | AME OF ECEASED (ype or print) #33674  | First<br>Walte |                                 | Middle                                   | Last  Berry  B. DATE OF BIRTH                             | 4 DATE<br>OF<br>DEATH             | Mant  AGE (In years      | h I IFUNDER 1 Y | 6 1               | 960r<br>DER 24 HRS      |
|          | Male Negro  | WID            | RRIED NE<br>OWED 105 KIND OF BU | DIVORCED 🔲                               | 5/29/94   |                                   | ost birthday)<br>72 yrs. | Manths D        | Days Hour         | rs Min                  |
| durin    | ig most of working life, even if reti<br><u>Unknown</u><br>FATHER'S NAME                                    | red)           | INDUSTRY                        |  | Ohio  |                                   |                          | COUN            | USA               |                         |
|          | George Berry  | D FORCES?      | 16. SOCIAL SE                   | CURITY NO. 17                            | Enni.   |                                   | Addre                    | 255             |                   |                         |
| (Yes     | WAS DECEASED EVER IN U.S. ARME<br>, no, or unknown) (If yes give wo<br>Yes<br>IB. CAUSE OF DEATH (Enter on  |                | Unknow                          | m  | Hospital R  | ecords                            | 10                       | ower            | INTERVAL          | BETWEEN                 |
|          | PART I DEATH WAS CAUSE  |                |                                 |  | opneumonia,   | marke                             | d both lo                | obes            | ONSET AND         | ) DEATH                 |
|          | Conditions, if any, which gove rise to immediate cause (a), stating the underlying couse last.              | (b)<br>DUE TO  |                                 |  |   |                                   |                          |                 |                   |                         |
| ATION !  | PART II OTHER SIGNIFICANT COL   | ontribi        | associa                         | ated with                                | Cerebral Ar   | terios                            | Terosis                  |                 | 19. WAS A PERFO   | RMED?                   |
| CERTIFIC | 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF D (IF EITHER, NOTIFY MEDICAL EXAM                     | EATH<br>INER)  | 205. DESCRIBE H                 | OW INJURY OCCURRED.                      | (Enter noture of injury in                                | Part I or Po                      | rt II of item 18.)       |                 |                   |                         |
| MEDICAL  | 20c. TIME OF INJURY Month, D<br>Haur a m.<br>p.m.   |                |                                 |  | CE OF INJURY (Home, for<br>tary, street, affice bldg., et | r.) _                             | (City or town)           | (Coun           |                   | (Stote)                 |
|          | 21. I certify that (i) saw the deceased ali   |                | attended the<br>3/6/            | deceased fram_<br>19 <u>67</u> , and the | 10/26/<br>it death accurred c                             | 19 <u>66</u> ,<br>il <u>:30</u> 1 | no3/6/<br>M, fram causes | and on the      |                   | ) (we) las<br>ted above |
|          | 22c. PHYSICIAN'S  | l.             | Drike                           | in, M                                    | D PHYS 22d ADDRESS  | MED<br>DIRECTOR                   | STAFF PHYS.              | 3/6/6           |                   |                         |
| /        | NAME (Type) C. ]  | Oorkan . I     |                                 | NAME OF CEMETERY OR                      | Crownsyi  |                                   | ate Hosp                 |                 | Maryla<br>County) | (Stote)                 |
|          | BURIAL, CREMATION, RIMOVAL (Specify) 231  | 3/10/6         | 2 B                             | ADDRESS /                                | GT. CFUN  | CD BY REGIST                      | OI FrE                   | EGISTRAR'S SIG  | AVE<br>GNATURE    | mil.                    |
| ١        | Elliott Fu  | HETAL          | Hop                             |  | brolinger!  | MAK I (                           | 1967                     | Jelian          | es ym             | Jac.                    |

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03018 CERTIFICATE OF DEATH deeth 21 Maurs after diath and campletely filled in by the funeral remove carban papers. Pages 1 and 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH b. COUNTY a COUNTY MARYLAND ban papers. Pages 1 within 72 haurs after ELENGTH OF STAY IN 16 b CITY OR TOWN (f autside carparate limits, autside corparate limits, write RURAL and give nearest tawn) d STREET ADDRESS e. IS RESIDENCE ON A FARM? WON (If not in hospital, give street address) ISTE 1400 YES NO 1 requires that th∎ death certificate be executed within NAME OF Middle Last DATE Month Dov Year DECEASED OF DEATH 19 event. (Type or print) IF UNDER 1 YEAR IF LINDER 24 HRS 6 COLOR OR RACE NEVER MARRIED 9. AGE (in years Months Days Hours DIVORCED WIDOWED 12 CITIZEN OF WHAT 10h, KIND OF BUSINESS OR 10a USUAL OCCUPATION (Give kind of work done OMS FATHER S NAME 13 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO INFORMAN] unknown) (If yes give wor or dates of service INTERVALBETWEEN 18. CAUSE OF DEATH (Enter only one cause per ligerfor (a), (b), and (c).) burial-transit PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) signed by DUE TO burial Conditions, if ony, which gove nse to immediate cause (a), DUE TO stoting the underlying couse as the has been last. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) USE far use Health NO A ficate the haspital ar 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of Item 18.) 20a ACCIDENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e, PLACE OF INJURY (Home, form, (City or town) (County) (State) 20d INJURY OCCURRED 20c. TIME OF INJURY Month, Day, Year factory, street, affice bldg., etc.) Hour o.m. While Not While TO FUNERAL DIRECTOR: After 1967, that (I) (47e) last 2). I certify that (1) (this hospital) attended the deceased fram\_ be retained shauld and that death accurred a M. fram causes and an the date stated above. saw the deceased alive an 220. SIGNATURE 22b DATE SIGNED ATTENDING DIRECTOR PHYS. be filed 22d. ADDRESS 22c. PHYSICIAN S O HOSPITAL Page 4 may NAME (Type) RICHARD directar, shauld NAME OF CEMETERY OR CHEMATOR LOCATION (City of Town) (State) 23a. BURIAL, CREMATION REGISTRAR S SIGNATURE 250, REC'D BY REGISTRAR 2Sb. **FUNERAL DIRECTOR** 1967

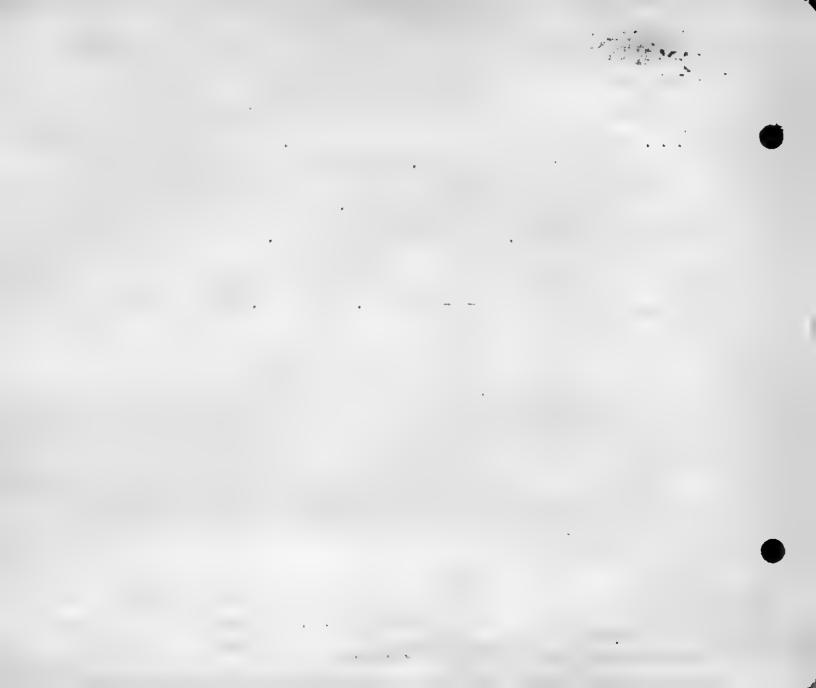


Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 03019 mapries that the death certificate be executed within 24 haurs after death. de de ch PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY a. STATE b. COUNTY ely filled in by the fundon papers. Poges 1 c Anne Arundel MARYLAND Maryl and b CITY OR TOWN (If outside carparate I mits, c. LENGTH OF STAY IN 15 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) Crownsville vr. 2 mos. Baltimore d NAME OF HOSP TAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Crownsville State Hospital NO € 531 N. Patterson Park YES 3. NAME OF ond-completely f pou Middle Lost 4. DATE Month Year Doy DECEASED (Type of print) #34412 Samuel Bivens 19 67 amy event, DEATH 5 SEX IF UNDER 1 YEAR IF UNDER 24 HRS 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 8 DATE OF BIRTH AGE (In years remove in amy eve Manths lost birthdoy) Doys Hours WIDOWED X 10/29/1881 Male Negro DIVORCED 10o USUA, OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State or foreign country) 12. CITIZEN OF WHAT attending physician o permit. Then please i ion, or removal, and in during most of warking ite even if retired) **COUNTRY?** INDUSTRY Retired Porter Marvland USA 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME signed by the attending physiburiol-transit permit. Then planned, cremation, or removal, Unknown Marv 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, ar unknown) (If yes give war ar dotes af service) No 216-09-5047 Hospital Records INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) ONSET AND DEATH PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (0) Pulmonary Embolism (?) DUF TO Canditions, if any, which gave (b) Ca of the Prostrate rise to immediate cause (a). DUE TO TO HOSPITAL OR ATTENDING PHYSICIAN: The law Poge 4 may be retained by the hospital or attending stoting the underlying couse as the prior to X (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED? 10 FUNERAL DIRECTOR: After this certificate had director, page 3 shauld be detoched for use should be filed with the State Dept. of Health NO XX C.N.S. Syphilis Latent: Chronic Brain Syndrome 200 ACCIDENT WAS UNDERLYING 70b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Hame, form, (City or town) (County) (Stote) 29c. TIME OF INJURY Month, Day, Year foctory, street, office bldg., etc.) Not While at work ot wark 1/24/ , 19<u>67</u>, that (I) (we) last 2). I certify that (I) (this haspital) attended the deceased fram. 1966 ta 1967, and that death accurred at 6:05 M, from causes and an the date stated above saw the deceased alive and 22b. DATE SIGNED 220 SIGNATURE XX 3/1/67 M.D. DIRECTOR PHYS. PHYS 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Benedict. Crownsville State Hospital 23d. LOCATION (City or Town) 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 230 BURIAL, CREMATION (County) 3/6 Baltimore, Mt. Auburn Maryland 256 REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR 1967 Charles A. Rice 661 W. Barre St. 20 M 1/66

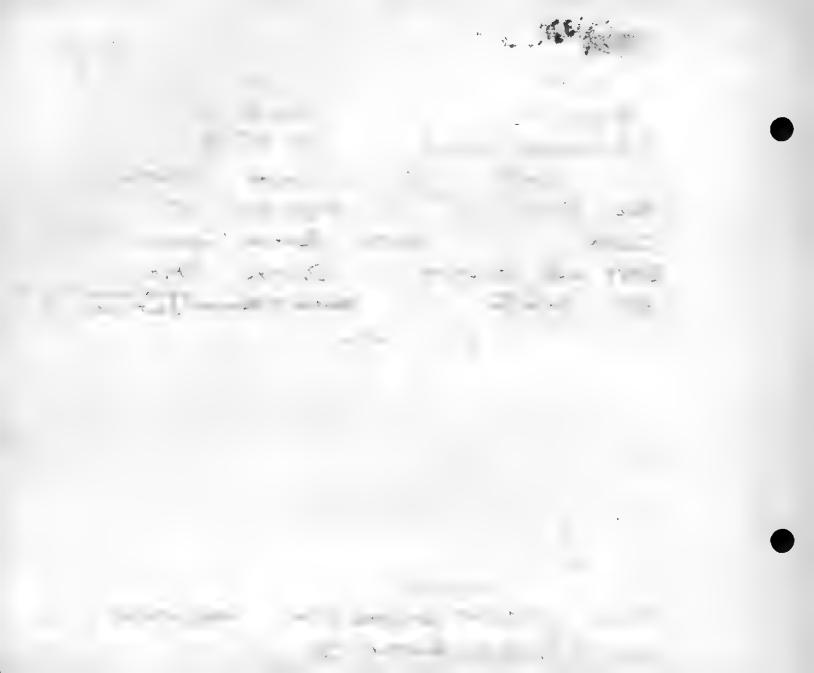
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased fixed, if institution Residence before admission), a. COUNTY Anne Arundel Marvland Prince Georges MARYLAND b CITY OR TOWN (If outside corporate I mits, c LENGTH OF STAY IN 15 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) Seat Pleasant Annapolis 4 days d. NAME OF HOSPITAL OR INSTITUT ON (If not in haspital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? 6914 George Palmer Highway YES NO Anne Arundel General Hospital 3 NAME OF First Middle 4. DATE Year DECEASED OF DEATH BLACKWELL, III Andrew David 19 67 March (Type or print) S SEX B. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 6 COLOR OR RACE 7 MARRIED 9 AGE (In years NEVER MARRIED ost birthdoy) remo White WIDOWED DIVORCED Aug. 19, 1966 Male 100 JSUAL OCCUPATION (Give kind of wark done 12 CITIZEN OF WHAT 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) during mast af wark ng life, even if retired) INDUSTRY COUNTRY? physician ren pleose Infant Maryland 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME signed by the attending physi burial-tronsit permit. Then pl burial, cremotion, or removal, Andrew David Blackwell, jr Duling 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Address Seat Pleasan (Yes, na, ar unknown); (If yes give wor or dotes of service) Andrew David Blackwell Jr. 18. CAUSE OF DEATH (Enter only one cause per lipe) for (p) (b) and (c).) INTERVAL BETWEEN PART I DEATH WAS CAUSED BY. ONSET AND DEATH IMMEDIATE CAUSE (o' Conditions, if any, which gove rise to immediate couse (a), DUE TO stating the underlying couse 3 should be detached for use as the with the State Dept. of Health prior to WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? NO XIX TO FUNERAL DIRECTOR: After this certificate 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 1B.) 20a ACCIDENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) TIME OF INJURY Manth, Day, Year (State) Hour a.m. foctory, street, office bldq., etc.) Not While ot work ., 19 67, to Mar. 1 , 19<u>67</u>, that (I) (3024) last sow the deceased alive on which 25 and that death accurred at M, fram causes and an the date stated above. 220 SIGNATURI 22b\_DATE SIGNED House DIRECTOR director, page 3 should be filed v M.D. PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Antonio M. Rivera, M.D. SouthRivMedCent. Edgewater, Md. 23a BURIAL, (REMATION, REMOVAL (Specify) Burial 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) 3/4/67 Congressional Washington. 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR 2Sa. REC D BY REGISTRAR VR A15 (4) 20 M 1/66 Lee Funeral Home Washington, D.C. DATE MAR 6



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND FOR STATE MEDICAL EXAMINER'S DEATH ALTH DEPT 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased | ved. if institution, Residence before edmission, a. COUNTY necessary, ector Page b. COUNTY Maryland Anne Arundel Anne Arundel MARYLAND b. CITY OR TOWN (if outside corporate limits. c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outs da corporate limits, write RURAL and give nearest town) write RURAL and give nearest town! Edgewater Annapolis, M d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS a. IS RESIDENCE ON A FARM? Anne Arundel General Hospital Box 638 Rt. D.O.A. YES NO X B. NAME OF 4. DATE Day Month Y .... Š within 24 hours after death. If an 18. Give Pages 1, 2, and 3 to the ofen PM3. Page 5 may be retain. File pages 1/6µd 2, with the 5 DECEASED OF DEATH 6. COLOR OR RACE 7. MARRIED | NEVER MARRIED 8 DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS last birthday) Davs Hours 68 WIDOWED DIVORCED [ male 10a USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State or fore gn country) 12, CITIZEN OF WHAT COUNTRY? done during most of working I fe, even if retired) Millright(ret Mechanical Sharon, Pa. USA 13. FATHER'S NAME 4 MOTHER'S MAIDEN NAME Simmion Blair Pauline Blaga 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unkown) | (If yes give war or dates of service) EDICAL EXAMINER: This certificate should be executed Mrs. Catherine L. Blair 209**-**05-1098A same as 18. CAUSE OF DEATH [Enter only one cause per june for (a), (b), and (c) ] INTERVAL BETWEEN Office along ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause DUE TO 35 (e), stating the underlying cause last, PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (181) 19. WAS AUTOPSY CERTIFICATION PERFORMED? 20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part or Part II of item 18.) PRIMARY \_ or CONTRIBUTING \_ WEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. NJJRY OCCURRED 20s PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) While Not While Hour a.m. at work at work 21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion Homicide Suicide Undetermined manner death resulted from CH EF MEDICAL EXAMINER ACTUAL should be FUNERAL ASSISTANT MEDICAL EXAM NER DATE SIGNED SIGNATURE DEPUTY MEDICAL EXAMINER EXAMINER'S 70 NAME (Type) Address (Street, city, fown, or county) please 4 shoul O FUN Health 228. BURIAL, CREMATION, 226. DATE THEREOF 22c NAME OF CEMETERY OR CREMATORY 22d, LOCATION (City, town, or country) (State) REMOVAL (Specify) March 6, 1967 Baltimore National Cem. Burial Baltimore B 1987 VCL VR A15ME MAI 5M 1/62 Annazolis



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) PLACE OF DEATH b. COUNTY n. COUNTY Poge jo MARYLAND (If outside corporate limits, write RURAL and give nearest town) CLENGTH DE STAY IN 16 b CTY DR TOWN (It outside corporate I mits, PM3. TUTION (tr not in hospital, give street address) ON A FARM? 24 hours ofter deoth Office along with DATE NAME OF DECEASED MARCH DEATH AGE SEX NEVER MARRIED 7 MARR FD Months Hours iget by hday) WHITE WIDDWED DIVDRCED 12 CITIZEN OF WHAT 10b KIND OF BUS NESS OR 10o LSUAL OCCUPATION (Give kind of work done) pending" in pencil in of Medical Examiner's 13. FATHER'S NAME be exercted within LOYOM File 16 SOCAL SECUR TY NO 17 INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? event within INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (a), (b) and (c)) ONSET AND DEATH **burial-transit** PART I DEATH WAS CAUSED BY: farwarded to the Chief IMMEDIATE CAUSE (o) ecolen This certificate should DUE TO Conditions, if any, which gave (b) rise to immediate couse (a), ⊆ DUE TO stating the underlying couse Inst. WAS AUTOPS)
PERFORMED? PART IN OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c) NO 20p EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port or Port I of tem B) PRIMARY Or CONTRIBUTING ö CAUSE OF DEATH (County) 20d INJURY OCCURRED 20e PLACE OF INJURY (Home form. (( ty or town) 20c. T.ME OF NouRY Month, Day, Year factory, street, office blog., etc.) Hour a.m. Not While of work of work 21. I certify that Litook charge of the remains described above held an Autopsy Inspection 🕞 and in my apinion Undetermined monner depth resulted fromy Accident Suicide Homicide CHIEF MEDICAL EXAMINER 22. DATE SIGNED ACTUAL ASSISTANT MEDICAL EXAMINER SIGNATURE Health prior FUNERAL the funeral DEPUTY MEDICAL EXAMINER **EXAMINER'S** Address (Street city, town or county) NAME (Type) ROSEDALE CEM. 25 n REC D BY REGISTRAR VR A15ME (5) 6M 1/67





|               | Division of STATISTICAL RES  |                                   |  |   | _                                      |
|---------------|--|-----------------------------------|--|---|--|
| 1             | 03024  | CERTIFICATE                       | OF DEATH                                   |   | 3016                                   |
|               | PLACE OF DEATH  o. COUNTY  |                                   | 2 USUAL RESIDENCE (Where deced<br>o, STATE | b COUNTY                                    | before admission)                      |
|               | b CITY OR TOWN (If outside corporate limits,                                   | MARYLAND  c. LENGTH OF STAY IN 16 | Maryland c CITY OR TOWN (if outside corpor | AnneArur                                    | ndel                                   |
|               | MELLE CONTROL OF THE SECOND  | 0.0. A.                           | Linthicum                                  | are limits, write KUKAL and give            | 6.1                                    |
| 77            | d NAME OF HOSPITAL OR INSTITUTION (If not in hospital North Arundel Hospi      | l, give street oddress)           | d STREET ADDRESS 200 E/ Bento              | n Ave.                                      | e IS RESIDENCE<br>ON A FARM?<br>YES NO |
| 3.            | NAME OF First  | Middle                            | Lost 4. DATE                               | Month                                       | Doy Year                               |
| L             | (Type or print) WILLIAM  | LOUIS                             | BROWN OF DEATH                             |   | 27 19 67                               |
| 5             | 6. COLOR OR RACE 7. MARRIE  Male White WIDOWE                                  |                                   | B. DATE OF BIRTH                           |   | YEAR IF UNDER 24 HRS. Doys Hours Min.  |
| 10            | to USUAL OCCUPATION (Give kind of work done 10b                                | KIND OF BUSINESS OR               | 11 BIRTHPLACE (County & State, or f        | 12 CITI                                     | ZEN OF WHAT                            |
| diu           | ring most of working the even il retted (ret) A.                               | A.Co. Police Da                   |  | , Maryland (OV                              | J.S.A.                                 |
|               | 3. FATHER'S NAME   |                                   | 14. MOTHER'S MAIDEN NAME                   |   |  |
|               | William L. Brown   |                                   | Caroline V.                                |   |  |
| 15            | fas no artifications) (if was also was as dates of care sa)                    | 6. SOCIAL SECURITY NO 17 I        | nformant<br>c. George Brown                | -Balto. Mo.                                 | Circle                                 |
|               | 18. CAUSE OF DEATH (Enter only one couse per line PART I. OEATH WAS CAUSED BY: |                                   |  |   | INTERVAL BETWEEN<br>ONSET AND DEATH    |
|               | H201 IMMEDIATE CAUSE (o)   | Coronary 71                       | TO NOTO SEE                                |   |  |
|               | Conditions, if ony, which gove ) (b)   | thero-bel                         | eroses gena                                | roluziel                                    | 10 400.                                |
|               | rise to immed one couse (o), Storing the underlying couse                      |                                   | )()  |   |  |
|               | lost.   (c)  | <u> </u>                          | · ·  |   |  |
| ATION S       | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING                             | G TO DEATH BUT NOT RELATED TO 1   | HE TERMINAL DISEASE CONDITION GIV          | EN IN PART 1(0)                             | 19 WAS AUTOPSY<br>PERFORMED?<br>YES NO |
| CERTIFICATION | 20o ACC DENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  20b.             | DESCRIBE HOW INJURY OCCURRED      | Enter noture of injury in Port I or Po     | rt II of item 18.)                          |  |
|               |  | . INJURY OCCURRED 20e, PLAG       | E OF INJURY (Home, form, 20f.              | (City or town) (Coun                        | ity) (Stote)                           |
| MEDICAL       | Hour o.m. 19 of w  | ile Not While foch                | ory, street, office bldg., etc.)           | (City of lown) (Coun                        | (20018)                                |
|               | 21. I certify that (I) (this hospital) ofte                                    |                                   | 1-24,1966,                                 | to 12-18-196                                | 6 that (I) (we) last                   |
|               | saw the deceased alive on 12 -   | 1961, and that                    | death occurred at                          | M, from causes and on the                   | date stated above                      |
|               | 220 MG VATURE  | 11 11 11 11                       | ATTENDING MED.                             | STAFF   12b. DAT                            | = 2-8,1967                             |
|               | 200 PHYSICIAN'S  | M.C. M.C                          | PHYS. OIRECTOR  22d. ADDRESS               | PHYS LI 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | -20,276/                               |
|               | MAME (Type)  | ager                              |  | Hosp. Baltimo                               | ore, Md.                               |
| 23            | O BURIAL, CREMATION, 23b DATE THEREOF  | 23¢ NAME OF CEMETERY OR O         | REMATORY 23d L                             | OCATION (City or Town) (C                   | ounty) (Stote)                         |
|               | PEMOVAL (Specify)  |                                   |  |   |  |
|               | Surficial (Specify) 3/30/67  | Cedar Hill (                      |  | oklyn, R.F.O.                               | Md.                                    |



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03025 CERTIFICATE OF DEATH 2 pap death PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) the attending physician and completely filled in by the funeral sit permit. Then please remove, as bongers. Pages I and mation, or removal, and in any event; within 72 hours after feat a COUNTY o. STATE b. COUNTY Anne Arundel Maryland Anne Arundel MARYLAND b. CITY OR TOWN (If autside carporote I mits, write RURAL and give negrest town)
Annapolis CLENGTH OF STAY IN 15 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis 5 days e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITA, OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS Anne Arundel General Hospital 2 Hull Avenue, Bay Ridge NO [30] NAME OF First 4. DATE Year DECEASED BUCKLEY 167 March Elizabeth Madeline (Type or print) DEATH 9 AGE (In years IF JNDER 1 YEAR IF UNDER 24 HRS. S SEX 6. COLOR OR RACE 8. DATE OF BIRTH 7 MARRIED NEVER MARRIED Months Days Hours August 3, 1884 White WIDOWED Female 11. BIRTHPLACE (County & State, or foreign country) 10o, USUA, OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT COUNTRY? during most of warking life, even if retired) **INDUSTRY** Illinois attorney Gov't. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Maurice Buckley Johanna Enright WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17 INFORMANT Address (Yes, no, or unknown) (If yes give war ar dates of service 220-44-0419T Miss May B. no Eastman INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) burial-transit PART I. DEATH WAS CAUSED BY-IMMEDIATE CAUSE (a) DUE TO Conditions, if ony, which gave rise to immediate cause (o). DUF TO for use as the b stating the underlying cause **O HOSPITAL OR ATTENDING PHYSICIAN:** The law re Page 4 may be retained by the hospital or attending O FUNERAL DIRECTOR: After this certificate has been 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO 20a ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) (County) (State) 204 INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20c TIME OF INJURY Month, Day, Year factory, street, affice bldg., etc.) 2). I certify that (i) stoicednessignal attended the deceased from MAY 10, 1962, to March 4, 1967, that (i) (1964) last saw the deceased alive an 3 MARCH 1967, and that death accurred at M, fram causes and an the date stated above. 22b. DATE SIGNED 22n. SIGNATURE X M.D. DIRECTOR director, page should be filed PRYSICIAN 22d. ADDRESS NAME (Type) Edward S. Beck. M.D. 73 Franklin St., Annapolis, Md. 23d LOCATION (City or Town) 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23a. BURIAL CREMATION. (County) (State) REMOVAL (Specify) all Mar. 5,1967 Richland Joseph's Catholic 2Sb. 2So. REC'D BY REGISTRAR Hopping 1987 VR A15 (4) 20 M 1/66 FUNLRAL HOME Annapolis







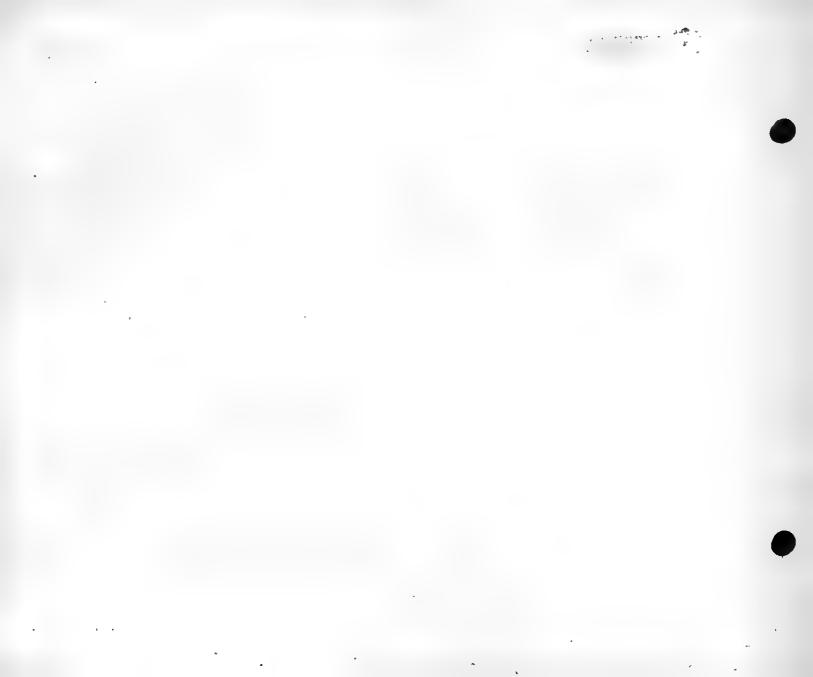
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| '   mark D   | MARYLAND STATE DEPARTMENT OF HEALTH  Privision of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  Them #9 Film #0135 3/14/57 pc |   |  |  |   |  |  |  |  |
|--|---|---|--|--|---|--|--|--|--|
| 03028  | Item<br>N   | #9 Film #GT 5'                                  | 3/14/57 pc<br>S CERTIFICATE OF                                       | DEATH  | กลกอก   |  |  |  |  |
| I PLACE OF DEATH                                   | 9.17.Co.  | MARYLAND  | o STATE  | nere deceased lived if institu                   | tion Residence before admission) NTY              |  |  |  |  |
| wrte RURAL and                                     | outside corporate lants<br>g ve nearest town)<br>Len Eurnie   | c LENGTH OF STAY IN 16                          | C. CHY OR TOWN (IF outs  | de corporate mits, write RJ                      |   |  |  |  |  |
| NOR!   | OR INSTIUTION (I not in hasp  | . 11 . 11                                       | d STREET ADDRESS   | aray Koos  | B IS RESIDENCE<br>ON A FARM?<br>YES , NO          |  |  |  |  |
| 3 NAME OF<br>DECEASED<br>(Type or print)           | Vergle  | M date  | Chaney   | 4 DATE Mon<br>OF<br>DEATH 3                      | 7 1967  |  |  |  |  |
| female   | 6 COLOR OR RACE 7 MAR White WIDO  | WED DIVORCED                                    | 8 DATE OF BIRTH  | 9 AGE (In years<br>lost hirthdoy)<br>80 84 Yrs   | Manths Days Hours Min.                            |  |  |  |  |
| during most of working li  cook  13. FATHER'S NAME | e, even if retired)   | OB. KIND OF BUSINESS OR INDUSTRY  restaurant    | Strausburg  14 MOTHER'S MAIDEN NA                                    | Va   | 12 CITIZEN OF WHAT COUNTRY?                       |  |  |  |  |
| John Mite  | chell IN U.S. ARMED FORCES?  If yes give war at dates at service)   | 16 SOCIAL SECURITY NO                           | Idie Fa  | lmer<br>468 Oaktown                              | ess Ave.  |  |  |  |  |
| 18 CAUSE OF DEA                                    | ATH (Enter only one cause per in  |   | John G. Chaney   |  |   |  |  |  |  |
| Onditions, if ony,                                 | IMMEDIATE CAUSE (o)  DUE TO   | Julian J  | (oden  |  | 24 hr.  |  |  |  |  |
| rise to immediate<br>stating the underl            | couse (o),  |   |  |  |   |  |  |  |  |
| PART II. OTHER SIG                                 | NIFICANT CONDITIONS CONTRIBUT   | TING TO DEATH BUT NOT RELATED                   | TO THE TERMINAL D SEASE COND   | ITION GIVEN IN PART 1(0)                         | 19. WAS AUTOPSY PERFORMED? YES NO                 |  |  |  |  |
| 200 EXTERNAL CAU PRIMARY Or CON CAUSE OF DEATH.    | TRIBUTING   | DESCRIBE HOW INJURY OCCURR                      |  |  |   |  |  |  |  |
| Hour o.m.  | 19 c  | While Not While I                               | PLACE OF INJURY (Home, tarm,<br>factory, street, office bldg., etc.) | 20f (City or town)                               | (County) (State)                                  |  |  |  |  |
| 21. I certify<br>death results                     |   | e remains described above,<br>es , Accident , S | uicide 🔲, Homicide (   | , Undetermined n                                 | uiry <del>], a</del> nd in my apiniai<br>nanner ] |  |  |  |  |
| ACTUAL<br>SIGNATURE                                | Mules   | udl ,   | CHIEF MEDICAL E.  M D ASSISTANT MEDIC DEPUTY MEDICAL                 | AL EXAMINER .                                    | 22. DATE SIGNED                                   |  |  |  |  |
| EXAMINER'S<br>NAME (Type)  230 BURIAL, CREMATION   | 23b. DATE THEREOF   | 23c NAME OF CEMETERY                            | Address (Street,   | city, town, or county)  23d LOCATION (City or To | 3/1/67<br>(wn) (County) (State)                   |  |  |  |  |
| REMOVAL (Specify) Burial                           | March 8.19  |   | eme terv   | Odenton  | A A Md  |  |  |  |  |
| HOPPING 1  | E. Hopping -/   | - Annapolis, Md                                 | Taken 1  | 0 1967 gc  | iarles Judge.                                     |  |  |  |  |



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH shoute 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution, Residence before admission) COUNTY a. STATE b. COUNTY Anne MARYLAND Ma Anne Arundel b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and giva nearest town) Glen Burnie Glen Burnie d, NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS a. IS RESIDENCE ON A FARM? YES NO W 106 Buckingham Ave Buckingham Ave papers. 3. NAME OF Middle DATE Month Year DECEASED OF (Type or print) DEATH and cor carbon 5. SEX DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 7. MARRIED [ last birthday) Months | Days Min. Sept Female WIDO WED -DIVORCED 10s. USUAL OCCUPATION (Giva kind of work 1Db, KIND OF BUSINESS OR INDUSTRY 1 12. CITIZEN OF WHAT COUNTRY? 11 BIRTHPLACE (County & State, or foreign country) done during most of working life, even if retired) USA 13. FATHER'S NAME MOTHER'S MAIDEN NAME Unk ۵ 15. WAS DECEASED EVER IN U.S. ARMED FORCES? I 16 SOCIAL SECURITY NO. 17. INFORMANT Address (Yas, por unkown) | (If yes give war or dates of service) Family Same 18. CAUSE OF DEATH |Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 165A DUE TO Conditions, if any, which 161 gave rise to immediate cause **DUE TO** (a), stating the underlying cause last. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY CERTIFICATION PERFORMED? NO 20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.) 20a, ACCIDENT WAS UNDERLYING [7] OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY 20d, INJURY OCCURRED 20s, PLACE OF INJURY (Home, farm (County) (State) Month, Day, Year 20f. (City or town) While Not While factory, street, office bldg., etc.) Hour a.m. al work at work 21. I certify that (I) (this hospital) attended the deceased from A (1) (we) last 19.6. , and that death occurred at A M, from the causes and on the date stated above saw the deceased alive on 22a, SIGNATURI 22b. DATE ATTENDING STAFF SIGNED PHYS. DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 23a. BURIAL, CREMATION, | 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) REMOVAL (Spacify) Md A A Co Cedar Hill Cem Duri คไ PEGISTRAP'S SIG 24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS REC'D BY REGISTRAR 25h VR A15 [4] McCully Funeral Heme 237 Patapsco Ave 21225 15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH

funeral

requires that the death certificate be executed

physician

aftending

physician.

signed by

FUNERAL

A STATE OF THE STA

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03030 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after deatl ond PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission o. COUNTY b. COUNTY Anne Amundel Maryland Anne Arundel completely filled in by the fur love carbon papers Pages I v event within 72 hours after it MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 15 c CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) 35 min. Arnold Annanolis d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? Anne Arundel General Hospital Box 110 YES NO TO NAME OF First Middle 4. DATE Day Year DECEASED COATES 22 67 William March (Type or pnnt) Roman 19 DEATH S. SEX IF UNDER TYEAR IF JNDER 24 HRS 6 COLOR OR RACE 7 MARRIED 8 DATE OF BIRTH AGE (In years NEVER MARRIED remove/ last birthdoy) Months Days Hours and in any Male Negro WIDOWED DIVORCED Feb. 24, 1905 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State or foreign country) 12 CIT ZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? attending physician sermit. Then please Construction Labor.
13. FATHER'S NAME Anne ArundelCo, Md U.S.A 计算经验的 or removal. John Henry Coates I Lavenia White 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) (If yes give war ar dates af service 16. SOCIAL SECURITY NO No 217-16-3049 Tula Price 20 Donest burial, crematian, **外外**等等等等等 18. CAUSE OF DEATH (Enter only one cause per Lineafar (a), signed by the burial-tronsit p PART I DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o **O HOSPITAL OR ATTENDING PHYSICIAN:** The law requires the Page 4 may be retained by the hosp tal ar attending physicion. DUE TO Canditions, if any, which gave rise to immediate cause (o). DUE TO stoting the underlying couse 19 WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) NO YY 200 ACCIDENT WAS UNDERLYING 206. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part or Port(1) of Item 18.) OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Hame, farm, (City or town) (County) (State) Hour Tourn. factory, street, office bldg., etc.) O FUNERAL DIRECTOR: After Mar. 22 , 1967, that (1) (300) lost 21. I certify that (I) (this has about attended the deceased fram be filed with the Mar. 22 19 67, and that death accurred at the deceased alive an\_ M, fram causes and an the date stated above 22 g SIG NATURE DATE SIGNED ATTENDING STAFF PHYS. M.D 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) 110 Clay St., Annapolis, Richardson, M.DL Md. director, 23d. LOCATION (City or Town) 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 230. BURIAL, CREMATION (Stote) REMOVAL (Specify) Carpenters Hill Md Burial 3-25-67 Anne Arundel Co 24 FUNERAL DIRECTOR 25a, REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE VR A15 (4) 25M 1/67 Charley C.E. Hicks, 111 Annapolis, Maryland



| CERTIFICATE OF DEATH  1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence (Where deceased lived, if I | ndel                                   |
|--|--|
| An e Aruniel  Maryland  C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Glen Burnie  d. Name of Hospital or Institution (if not in hospital, give street address)  Maryland  Maryland  C. CITY OR TOWN (If outside corporate limits, write RURAL development)  Severna Park  Development  d. STREET ADDRESS  | e. IS RESIDENCE DN A FARM?             |
| b. CITY DR TOWN (if outside corporate limits, write RURAL write RURAL and give nearest town)  Clen Burnie  d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  C. CITY OR TOWN (if outside corporate limits, write RURAL of Days  Severna Park  d. STREET ADDRESS  | e. IS RESIDENCE DN A FARM?             |
| The state of the s | YES NO N                               |
| Togeth Arms of the mit.  | YES NO N                               |
| Worth Arun el Ho pital   4 Rights Ave ue   3. NAME OF   First   Middle   Last   4. DATE   Month  |  |
| North Arun el Ho pital 4 Rights Ave ue  North Arun el Ho pital 4 Rights Ave ue  North Arun el Ho pital 4 DATE Month DECKASED (Type or print) Edith I Codd DEATH March  S. SEX 6. COLOR DR RACE 7. MARRIED NEVER MARRIED 6. DATE OF BIRTH 9. AGE (In years   Funder)   March    S. SEX 6. COLOR DR RACE 7. MARRIED NEVER MARRIED   8. DATE OF BIRTH 9. AGE (In years   Funder)   March    S. SEX 6. COLOR DR RACE 7. MARRIED NEVER MARRIED   8. DATE OF BIRTH   9. AGE (In years   Funder)   March    S. SEX 6. COLOR DR RACE 7. MARRIED NEVER MARRIED   8. DATE OF BIRTH   9. AGE (In years   Funder)   March    S. SEX 6. COLOR DR RACE 7. MARRIED NEVER MARRIED   8. DATE OF BIRTH   9. AGE   10 years   | 5 <b>19</b> 67                         |
| 5. SEX   6. COLDR DR RACE   7. MARRIED   NEVER MARRIED   8. DATE OF BIRTH   9. AGE (in years liftunder)   Months   1888   78 yrs.  | Days Hours Min.                        |
| White WIDOWED DIVORCED July 7 1888 78 yrs.  The state of working life, every if retired to the state of working life.  | CITIZEN OF WHAT                        |
| 16a. USUAL OCCUPATION (Give kind of work done during most of working life, ever if retired)  10b. KIND DF BUSINESS OR LIT. BIRTIPLACE (County & State, or foreign country)  11. BIRTIPLACE (County & State, or foreign country)  12. CI  13. FATHER'S NAME  14. MOTHER'S MAIDEN NAME   | . D. A.                                |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. APPCIAL SECURITY NO. L 17. INFORMANT Address   | N. I                                   |
| to the first of th | ena IK, his                            |
| 3. NAME OF FIRST Middle Last 4. DATE Month  POPULATION OF PRICE 1. MIDDLE 1. DATE MONTH  S. SEX 6. COLOR DR RACE 7. MARRIED NEVER MARRIED S. DATE OF BIRTH MARCH  White Body of Property of Working Life, every if retired of Middle Last 4. DATE MARCH  White Wildle Last 4. DATE MONTH  First Middle Last 4. DATE MONTH  First Middle Last 4. DATE MONTH  First MIDDLE 1. DATE MONTH  First Middle Last 4. DATE MONTH  First MIDDLE 1. DATE MONTH  First MIDDLE 1. DATE MONTH  First MIDDLE 1. DATE MONTH  FIRST MARRIED S. DATE OF BIRTH MARCH  FIRST WILDLE 1. DATE MONTH  FIRST MONTH MARCH  FIRST MONTH  FIRST MARRIED S. DATE OF BIRTH MARCH  FIRST MONTH  FIRST MONTH  FIRST MARCH  FIRST MONTH   | interval between onset and death Hours |
| gave rise to Immediate cause (a), stating the underlying cause last. (c) Securitize by fecturing underlying cause last.  | years.                                 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)  Cuterior Secretary  20a. ACCIDENT WAS UNDERLYING   20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  OR CONTRIBUTING   CAUSE OF DEATH  OR CONTRIBUTING   CAUSE OF DEATH  OR CONTRIBUTING   CAUSE OF DEATH  OR CHIEF HER. NDTIFF MEDICAL EXAMINER)  | YES NO                                 |
| 20a. ACCIDENT WAS UNDERLYING   20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  20c. Time Discription of Injury in Part I or Part II of Item 18.)  20c. Time Discription of Injury in Part I or Part II of Item 18.)  20c. Time Discription of Injury in Part I or Part II of Item 18.)  20c. Time Discription of Injury in Part I or Part II of Item 18.)  20c. Time Discription of Injury in Part I or Part II of Item 18.)   | J                                      |
|  | unty) (State)                          |
|  |  |
| SEE SE MED. STAFF  | DATE SIGNED                            |
| 22c. PHYSICIAN'S NAME (Type) MAX (FRANK 10) 22d. ADDRESS V25 SC (Lybic bluy Sentence) 23a. BORIAL, CREMATION 23b. DATE THEREOF 23b, NAME OF CEMETERY OR CREMATORY 23d. LOOPTION (City, town or countries) 23d. | m Benerio                              |
| 23a. BORIAL, CREMATION 23b. DATE THEREOF 23b, NAME OF CEMETERY OR CREMATORY 23d. LOOSTION (City, town or cou   | unty) (State)                          |
| 24. FONERAL DIRECTOR ADDRESS ( 258. REC'D BY REGISTRAR 256. REGISTRAR'S  | 'S SIGNATURE                           |
| VR AIS (4) Solut & Bananes Severna (K) no DATE 9 1967 yourse   | Judge                                  |



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03032 CERTIFICATE OF DEATH 04545 requires that the death certificate be executed within 24 haurs after death. g physician. funeral PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) o. COUNTY o. STATE b. COUNTY Anne Arundel MARYLAND Marvland b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C LENGTH DE STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Crownsville 20 Years d NAME OF HOSP TAL OR INSTITUTION (If not in haspital give street address) d. STREET ADDRESS e IS RESIDENC ON A FARM? Unknown Crownsville State Hospital YES NO pa. 3 NAME OF Middle Lost 4. DATE Month signed by the attending physician and campletely burial-transit permit. Then please remave carban burial, crematian, ar remaval, and in any event, with Doy Year DECEASED OF (Type or print) #1 0436 DEATH Manuel Correa S SEX IF UNDER 24 HRS 6. COLOR OR RACE 9 AGE (In years IF UNDER 1 YEAR 7 MARRIED B. DATE OF BIRTH NEVER MARRIED lost birthdoy) Months Doys Hours MIDOMED A DIVORCED Male Negro - - 90100 JSJAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Laborer TISA Unknown 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME Unknown **Hnknown** WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dates of service Unknown Unknown Hospital Records 1B CAUSE OF DEATH (Enter only one couse per line for (o), (b) ond (c))
PART I DEATH WAS CAUSED BY INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (6) R. Lobar Pneumonia DUE TO Conditions, if any, which gove nse to immediate couse (o), DUE TO stating the underlying couse as the has been lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? detached far use e Dept. af Health NO X ra FUNERAL DIRECTOR: After this certificate Dehydration, Emaciation, Arteriosclerosis (Generalized) 200 ACC DENT WAS UNDERLYING IT 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port 11 of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) (County) 20c TIME OF INJURY Month, Doy Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, farm, (Stote) Hour o.m. factory, street, office blda. etc ) Not White of work at work , 19\_47, ta\_ 3/25/, 19 67, that (I) (we) last 21. I certify that (I) (this haspital) attended the deceased fram. 5/28 4 may be retained 3/25/ 167, and that death accurred a 9:350 M, fram causes and an the date stated above. saw the deceased alive and 22a. SIGNATURE 22b DATE SIGNED ATTENDING M.D. DIRECTOR PHYS 22c PHYSICIAN'S 22d, ADDRESS NAME (Type) Crownsville State Hospital, Maryland Benedict Johns HopkinsSchool of 23o. BURIAL, CREMATION, 23d LOCATION (City or Town) (County) Med. Baltimore, Md. REMOVAL (Specify) 24. FLINERAL DIRECTOR VR A15 (4)



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03033CERTIFICATE OF DEATH 24 hours after death AME OF DECEASED TEND HOUR OF DEATH lef or Printle JOHN HENRY CORDES LACE OF DEATH IN BALTIMORE, MARYLAND USUAL RESIDENCE (Where deceased lived. If institution; ies dence befole 4. USUAL B. COUNTY ANNE ARUNDEL COUNTY کو MARYLAND FULL NAME OF (If not in hospital or institution, give street HOSPITAL OR oddress or location) (If outside city I mits, write RURA, and give township) INSTITUTION NR. BROOKLYN BALTIMORE 331 ORCHARD AVENUE D. STREET ADDRESS (Il tural, give location) 331 ORCHARD AVE. executed 5. SEX 6. RACE 9. AGE (in years MARRIED, NEVER MARRIED 8. DATE OF BIRTH If Under 1 Yr. Months: Dovs If Under 24 Hrs. remave WIDOWED, DIVORCED (specify) lost birthdoví Hours WIDOWED and IDA, USUAL OCCUPATION GIVE kind of work 108, KIND OF BUSINESS OR INDUSTR 1. BIRTHPLACE (Stole or foreign country) 12, CITIZEN OF certificate be done during most of working life, even if retired) WHAT COUNTRY? POSTMAN

13. FATHER'S NAME U.S. POST OFFICE NEW YORK U.S.A. 14. MOTHER'S MAIDEN NAME JOHN P. CORDES UNKNOWN death 15. Was Deceased Ever in U. S. Armed Farces?
(Yes, no ar unknown) (If yes, give war ar dates of service) attendii 6. SOCIAL 7. INFORMANT ADDRESS SECURITY NO equires that the a physician. YES WWI 6328 Mrs. Catherine Leschefsky the Insit Orchand 18. INTERVAL BETWEEN signed by burial-trans ONSET AND DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not meen the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, attending injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if ony, giving rise to the above couse (A) stoling the UNDERLYING CONDITION last. this cern. detached for ZTU. TIME (Month) (Lov) treom ιπουπ IZIE. INJURT OCCURRED ZTF. NOW DID INJUKT OCCUR OF INJURY While At Not While I (APPROXI At Work Work 22. I certify that (I) (this hospital) attended the deceased from that (I) (we) last saw the deceased alive on .... Page 4 may be retained DIRECTOR: and hour and from the couses stated above. (1) (We) (did) (did not) view the body after death. 23A. SIGNATURI 23B. DATE SIGNED Attending M.D. Med. Stoff Phys. Director FUNERAL PHYSICIAN'S 23D. ADDRESS 24A. BURIAL CREMATION, 24B. DATE 24D. LOCATION (City, town, or county) 0 REMOVAL (Specify) BURIAL Long Island National Farminodale New York 25M 1/67 25A. DATE REC'D BY HEALTH DEPT. 258. NAME OF REGISTRAK A DD RESS Ochania O. 1007



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF FOR STATE PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admiss on) o. COUNTY b. COUNTY death MARYLAND b CITY OR TOWN (If autside carporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town) PM3. Burnel Depart d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d STREET ADDRESS B IS RESIDENCE heurs Office along with form 101- Red Sloge, ofe YES NO X 3. NAME OF Middle 4. DATE Month Doy Year DECEASED 1967 4 .3 25 (Type or print) .⊑ DEATH 5 SEX 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7 MARRIED NEVER MARRIED 8 DATE OF BIRTH last birthdoy) Months Hours DIVORCED event 100 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPEACE (Stote or foreign country) 12 CIT ZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY ? d "pending" in pencil in Chief Medical Examiner's JayweR pencil 14. MOTHER S MAIDEN NAM be executed within File 5000 or removal, 18: CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY. Candare deserve IMMEDIATE CAUSE (o) certificate should 4500 crematian, farwarded to the Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse lost. burial, PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19 WAS AUTOPS) PERFORMEO? NO X YES agent, prior ta 20a EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) PRIMARY I or CONTRIBUTING I CAUSE OF DEATH (City or town) 20c TIME OF INJURY Month, Day, Year 2Dd INJURY OCCURRED 20e PLACE OF INJURY (Hame, form, (County) (Stote) Hour o.m. foctory, street, office bldg., etc.) Not While of work 21. I certify that I took charge of the remains described above, held an Autapsy Inspection 3 Inquiry 🖂 and in my apinion death resulted from: -Natural causes 🔀 Accident I Suicide | Hamicide Undetermined manner the funeral directar. CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE DEPUTY MEDICAL EXAMINER **EXAMINER'S** 5 may 70 FUNE Heolth NAME (Type) Address (Street, city, town, or county) 23o. BURIAL, CREMATION, 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) REMOVAL (Specify) REC D BY REGISTRAR VR A15ME (5) 6M 1/66



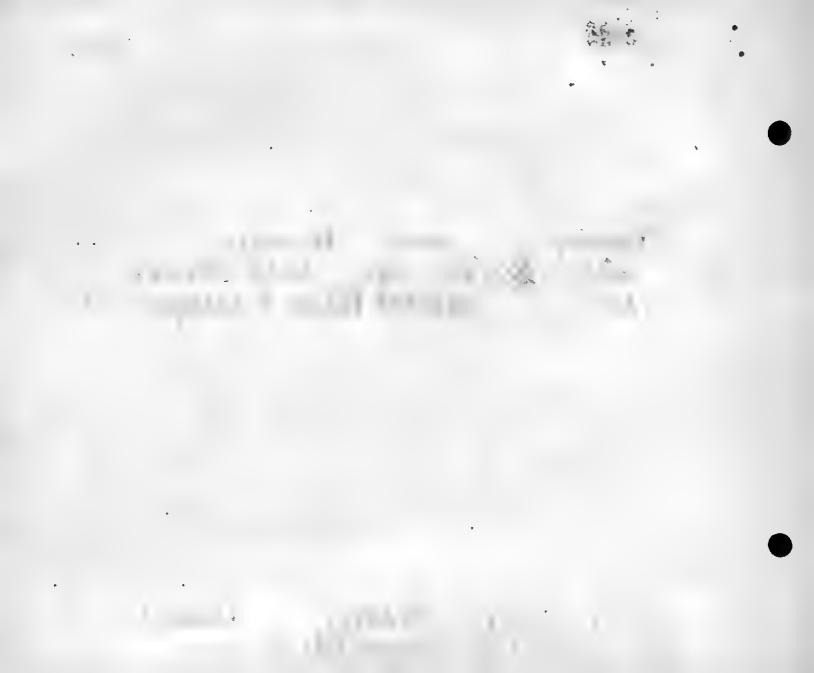
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03035 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAM: The low requires that the death certificate be executed within 24 haurs after death. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if Institution Residence before admission) o. COUNTY a. STATE b. COUNTY Anne Arundel Marvland Anne Arundel MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 c CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) Annapolis Annapolis d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) .⊆ d. STREET ADDRESS IS RESIDENCE Anne Arundel General Hospital 1219 McKinley St.. NO X YES 3. NAME OF Middle Lost DATE Year DECEASED DAVIDSON (none) Frank 67 (Type of point) DEATH March 19 IF UNDER 1 YEAR 6. COLOR OR RACE AGE (In years IF UNDER 24 HRS 7 MARRIED **NEVER MARRIED** 8. DATE OF BIRTH physicion and comi lost\_birthday) Months in any July 3, 1899 Male White 10o. USUAL OCCUPATION (Give kind of work done 12 CITIZEN OF WHAT 11. BIRTHPLACE (County & State or foreign country) during most of working life, even if retired) COUNTRY? Painter Scotland 14. MOTHER'S MAIDEN NAME 13 FATHER'S NAME burial, cremation, or removal, WILLIAM 17 INFORMANT Address WAS DECEASED EVER IN U.S. ARMED FORCES FREDAG. DAVIDSON 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN signed by the burial-transit PART : DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) O HOSPITAL OR ATTENDING PHYSICIAN: The law requires the Page 4 may be retained by the hospital ar ottending physicion. DUE TO Conditions, if any, which gove rise to immediate couse (a), DUE TO stoting the underlying couse director, page 3 should be detached for use as the should be filed with the State Dept. af Health prior to PART II OTHER SIGNIFICANT CONDITIONS CONTR. BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c) WAS AUTOPSY PERFORMED? NO XX 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 200 ACCIDENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20r TIME OF INJURY Month Day Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or fown) (County) (State) Hour o.m. factory, street, office bldg., etc.) at work TO FUNERAL DIRECTOR: After to Mar. 23, 19 67 that (1) 0000 lost 21. I certify that (1) (2000) attended the deceased fram\_1 March 23\_19 67, and that death accurred at M, fram causes and an the date stated above saw the deceased alive an 220 SIGNATURE 226 DATE SIGNED STAFF PHYS. d.M DIRECTOR ADDRESS 22c PHYSICIAN'S NAME (Type) 121 Cathedral St., Annapolis, Md. director, 23c NAME OF CEMETERY OR CREMATORY 23o. BURIAL CREMATION 24 FUNERAL DIRECTOR



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03036 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death, PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission a COUNTY Anne Arundel o. STATE Maryland b COUNTY Anne Arundel MARYLAND attending physician and campletely filled in by the f permit. Then please remave carban papers Pages an, ar remaval, «nd in any event, within 72 haurs afte c CITY OR TOWN (If gutside corparate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 b CITY OR TOWN (If gutside corparate limits, write RURAL and give negrest tawn) 3 months Churchton (Rural) Annapolis d NAME OF HOSP TAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Anne Arundel General Hospital Franklin Manor Road YES XX NO 4. DATE 3 NAME OF Middle Month First Last Day Уеаг DECEASED Samuel Kemp DAWSON DEATH March 1967 (Type or print) IF UNDER 24 HRS. IF UNDER 1 YEAR S. SEX 6. COLOR OR RACE B. DATE OF BIRTH 9 AGE (In years n any eve 7 MARRIED NEVER MARRIED gast birthday) Days Months Haurs 2 April 1875 Male Cauc. WIDOWED XX DIVORCED 10a USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State or fareign country) 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Churchton, Maryland
14 MOTHER'S MAIDEN NAME Farm 13. FATHER S NAME MARGARET REDECCA William DAWSON SIMMONS 17. INFORMANT Address Annapolis, Md. IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO permit. (Yes, no. or unknown) ((If yes give war ar dates of service) Katherine Gomoljak, 179 Defense Hgwy signed by the after burial-transit permi burial, crematian, a 216 18 5782 INTERVAL BETWEEN IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY ONSET AND DEATH Gram-negative septicemia IMMEDIATE CAUSE (a) DUE TO Chronic pyelonephritis ? years Canditions, if any, which gave rise to immediate cause (a). DUE TO stating the underlying couse as the prior to b Benigh prostatic hypertrophy has been ? years 19. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Cancer of stomach, Inanition due to pyelonephritis and carcinoma, Arteriosclerosis, Anemia due to cancer of stomach with hemorrhage 200 ACCIDENT WAS UNDERLYING D 205 DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.) No XIX TO FUNERAL DIRECTOR: After this certificate for OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Manth, Day, Year Haur a.m. 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm, (City or town) (County) (State) Not While factory, street, affice bldg., etc.) at wark at wark 2] I certify that (I) (this haspital) attended the deceased from 2] December 66, to 4 March, 1967, that (I) (we) last Page 4 may be retained director, page 3 should should be filed with the saw the deceased alive on 4 March 19 67, and that death accurred all 0: 30M, from causes and an the date stated above. 22b. DATE SIGNED 22g SIGNATURE **ATTENDING** M.D. PHYS DIRECTOR PHYS. 4 March 1967 22d. ADDRESS South River Medical 22c PHYSICIAN'S Charles W. Kinzer, M. D. Edgewater, Maryland 21037 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) 23g BURIAL, CREMATION, 23b DATE THEREOF ADDRESS FIELD REMOVAL (Specify) 2Sa. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR VR A15 (4) 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03037CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before odmission) o. COUNTY o. STATE b. COUNTY AnneArundel Maryland Anne Arundel MARYLAND b CITY OR TOWN (if outside corporate amits, write RURAL and give nearest town)
Annapolis c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 1b Annapolis d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? Anne Arundel General Hospital 240 B. Hilltop Lane NOXIX YES 3. NAME OF Middle 4. DATE First Month Doy Year DECEASED (Type or pnnt) OF DEATH DIMAGGIO Clara Francis 67 March COT S SEX 6. COLOR OR RACE 8 DATE OF BIRTH 9. AGE (In years IF JINDER 1 YEAR IF UNDER 24 HRS 7 MARRIED 179 NEVER MARRIED 9 4 6 5 last birthdoy) Months Doys Aug. 5, 1912 White Female WIDOWED reg 100 USUA, OCCUPATION (G-ve kind of work done 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT BIRTHPLACE (County & State, or foreign country) , even if retired) Maryland 13. FATHER'S NAME ar remaval, INFORMANT (Yes, no, or unknown) (If yes give wor or dates of service) burial, crematian, INTERVAL BETWEEN 18 CAUSE OF DEATH (Enter only one couse per line for (o) -transit PART I DEATH WAS CAUSED BY PINSET AND DEATH IMMEDIATE CAUSE TO DUE TO burial Conditions, if any, which gave rise to immed ote couse (a), DUE TO stoting the underlying couse fost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) WAS AUTOPSY PERFORMED? NO X 20o ACCIDENT WAS JNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port 8 of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour am. factory, street, office bldg, etc.) at work 19) / . to Mar. 1967, that (I) (1968) last 21 I certify that (I) (this happing) attended the deceased from, 19 67, and that death accurred at O FUNERAL DIRECTOR: saw the deceased alive an Mar. 9 M, from couses and an the date stated above. 220 SIGNATURE 22b. DATE SIGNED STAFF PHYS. M.D 22c. PHYSICIAN'S NAME (Type) 121 Cathedral St., Annapolis, Md. director, p



| DIVISION OF STATISTIC   | MAKTLAND STATE DEPART  | IMENI OF HEALIN<br>W. DRESTON STREET, RA                                  | LTIMORE 1. MARYLAND   |
|---|--|---|---|
| 03038   | CERTIFICATE OF   | DEATH   | กวกจก   |
| b. City OR TOWN (if outside corpor  | del MARYLAND   | STATE ME H  | bed lived, If institution, Residence before edmission b. COUNTY  O WARD  b. Bimits, write RURAL and give nearest town |
| rita RURAL and give nearest to  | (n)  | FIKNIDGE,   | 2.7  o. 15 RESIDENCE ON A FARM  |
| NAME OF (Type or print)   | irry Emorn   | 5608 Wesh   | Manth Blud YES NO Day Year  |
| SEX 6. COLOR OR   | RACE MARRIED NEVER MARTIED 8. DATE                                   | -10-1907 5  | St tin years IF UNDER TYEAR IF UNDER 24 MRS. It birthdey) Months Deys Hours Min.                                      |
| 10e. USUAL OCCUPATION (Give kind done during most of working life, even 13. FATHER'S NAME | Ship Yourd N   | BIRTHPLACE (County's Stele, offered  ACCOUNTY NOW'S  MOTHER'S MAIDEN NAME | Va. 12. CITIZEN OF WHAT COUNTRY   |
| 15. WAS DECEASED EVER IN U.S. ARM. (Yes, no or unkown) (Ifyesgivewererd                   |  | MARY WA   | Address Ellkridge   |
| 18. CAUSE OF DEATH [Enter of PART I. DEATH WAS CAUSED IMMEDIATE CAI                       | ly one cause per line for (e), (b), and (c).                         | 5608 W  | PSh. Blud 3777d<br>INTERVAL BETWEEN<br>ONSET AND DEATH  |
| Conditions, if any, which   | UE TO  (b) AVIONIOSE JORO LIC  UE TO                                 | Vascular o  | iserse lyer   |
| Probable muca   | conditions contributing to DEATH BUT NOT RELA<br>rdist nforction MZ. |   | DITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?  |
| 200. ACCIDENT WAS UNBERLYING OR CONTRIBUTING TI CAUSE OF DE                               | EATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter MINER)                | er nellure of injury in Pert I or Part II of                              | Item 18.)   |
| 20c. TIME OF INJURY Month, D<br>Hour e.m.<br>p.m.   | While Not While factory, stre  | eet, office bldg., atc.)  |   |
| 21. I certify that (1) (this saw the deceased alive on.                                   | — J) — — — — — — — — — — — — — — — — — —                             | occurred 8. A.M., from the  | a causes and on the date stated above   |
| 22c PAS. CRAN'S<br>NAME 14 YOFUM W. La  | M.D. P   | PHYS. DIRECTOR P  | Harch 13, 1910  |
|   | e thereof 23c. Name of CEMETERY OR CRI                               | Curtis Bay Coast  EMATORY 23d. LOCATION  F/K                              |   |
| 14 FUNERAL DIRECTOR'S SIGNATURE   | bottom Aprilico MC   | DATMAR 17 19  | 25b. REGISTRAY'S SIGNATURE  |
|   |  |   |   |



|  | MARYLAND STATE DEPARTMENT OF HEALTH  |                                 |
|--|--|---------------------------------|
| - (M)  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |                                 |
| FOR STATE  | 03039 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  | 03030                           |
| HEALTH DEPT.   | 1 PLACE OF DEATH O COUNTY O STATE  1 PLACE OF DEATH O COUNTY O STATE  1 PLACE OF DEATH O COUNTY O STATE  | Residence before odmission)     |
| ny is<br>3 to<br>age   | HANZ HAUNDEL MARYLAND IVIARY LAND  | YNNE HAUNDEL                    |
| y delay is<br>and 3 to<br>PM3. Page<br>artment of  | b (ITY OR TOWN (If outside corporate miss) c .ENGTH OF STAY IN 1b c CITY OR TOWN (If outside corporate limits, write RURAL mind gifte project 1944).   | 12-1                            |
|  | d NAME OF HOSPITA. OR INSTITUTION (If not in hospitol, gave street oddress)  d STREET ADDRESS  | e IS RESIDENCE<br>ON A FARM?    |
| th. I<br>nges<br>h for<br>tote   | 3 NAME OF First / Middle Lost 4. DATE Month  | Doy Year                        |
| fer death. I<br>Give Pages<br>ong with for   | (Type or print) MARION H. ESTABROOK DEATH MARCI  | H 2 1967                        |
| adon Grand   |  | FUNDER 1 YEAR   IF UNDER 24 HRS |
| 24 hours on tem 18 rs Office of longer   | 100 LS JAL OF CUIPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (State or foreign country)   | 12 CITIZEN OF WHAT              |
| n freers O   | during thost of working life, even if retired) INDUSTRY ME MASS.   | W.Z.W.                          |
| within 24<br>pencil in<br>xominer s<br>rile pages<br>haurs afte  | 13 FATHER'S NAME   | 2-14                            |
| d with per Exon Frie   | IS. WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17 INFORMANT 196 BROWN   | RTH<br>KDALE GARDEN             |
| ld be executed within<br>rd "pending" in pencil<br>Chief Medicol Exomine<br>fransit permit. File pag<br>event within 72 haurs  | (Yes, no or yinknown) (If yes give wor or gotes of service) Morion H. WAHL BLOOMFIELD  | D N.J.                          |
| e execute<br>pending"<br>ef Medico<br>ssit permit  | 18 CAUSE OF DEATH (Enter on y one couse per impotor (o) (b) and (c)) PART   DEATH WAS (AUSED BY  | ONSET AND DEATH                 |
| should be e<br>ne word "per<br>to the Chief I<br>burial-transit  | 4344 DUE TO DUE TO   | Judley                          |
| thould<br>the<br>unal-   | Conditions, if ony, which gave ) (b)   |                                 |
| certificate should<br>writing the word<br>rwarded to the Cl<br>sed as a burial-tr<br>rol, and in any ev  | rise to immediate cause (a), DUE TO  |                                 |
| rfication of the strategies of | lost (t)   | 19 WAS AUTOPSY                  |
| EXAMINER: This certificate should be executed within 24 hours ute the certificate, writing the word "pending" in pencil in Item I age 4 should be forwarded to the Chief Medical Exominers Office your files.  Page 3 should be used as a burial-transit permit. File pages I londer cremation, or removol, and in any event within 72 haurs after deat  | PART I OTHER SIGN F CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINA. D SEASE CONDITION GIVEN IN PART 1(0)   | PERFORMED? YES NO               |
| *=   | 200 EXTERNAL CAUSE WAS PRIMARY Or CONTRIBUTING CONTRIBUTION CONTRIBUTING CONTRIBUTING CONTRIBUTION CONTRIBUTI |                                 |
| INER: T<br>e certific<br>should b<br>files.<br>3 should<br>tion, or r  |  | (County) (State)                |
| EXAMINER: ute the certinged 4 should ryour files. Page 3 shou  | 20c TIME OF INJURY Month, Doy, Year Hour o m p,m 19 20d .NJURY OCCURRED While of work  | (1.1.1)                         |
| L EXA<br>ecute<br>Page<br>ar you<br>ar you<br>R: Pag   | 21 I certify that I taak thange of the remains described above held an Autopsy, Inspect on, Inquiry  | and in my apinian               |
| CTO FOR MANUAL STATES  | death resulted from. Natural causes . Accident . Suicide . Hamicide . Undetermined mani  | ner 🗌                           |
| MEDICA<br>lease e<br>director<br>stained<br>DIRECT   | ACTUAL  SIGNATURE  ACTUAL  ACT | 22 DATE SIGNED                  |
| JIY MEDIC<br>rry, please is<br>eral directol<br>be retained<br>RAL DIRECT  | SIGNATURE  M D  ASSISTANT MEDICAL EXAMINER  EXAMINER'S  DEPUTY MEDICAL EXAMINER  | 21/1                            |
| SS OF THE PER COLUMN AND A PER COLUMN AN | NAME (Type) F. LIND PR. 4. Address (Street any town or county)   | 3/2/67                          |
| nece<br>the the S<br>S much<br>Heol  | 230 BURIAL CREMATION 23b DATE THEREOF 23c, NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town)  BENOVAL (Specify) 3-3-1967 FOAT LINCOLN PRINCE GE  | C 4 A                           |
| Va Alene in C  | 24 FUNERAL DIRECTOR ADDRESS 250 RECD BY REG STRAR 25b REG S  | TRARS SIGNATURE                 |
| VR A15ME (5)<br>6M 1/67  | JOHN M. TAULOR SONS AUNGROUS MD DATE MAR 6 1967  | Marles Judge                    |



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03040 CERTIFICATE OF DEATH The law requires that the death certificote be executed within 24 hours after death physician ond completely filled in by the funeral en please remove corbon, popers Poges 1 and oval, and in o≡y event within 72 hours after dead PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. STATE o. COUNTY Anne Arundel MARYLAND mary land c CITY OR TOWN III outside corporate limits, Write RURAL and give nearest town) b CITY DR TOWN (If autside carparate limits. C LENGTH DE STAY IN 16 write RURAL and give nearest town) 8 days Crownsville Severna Park d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? 4 Luna Lane YES NO X Crownsville State Hospital 3 NAME OF Middle Lost 4. DATE Month Day Year DECEASED (Type or print) #34888 Fiske Street DEATH Roland IF UNDER 24 HRS SEX 6. COLOR OR RACE 7 MARRIED TY NEVER MARRIED B. DATE OF BIRTH 9 AGE (In years last birthday) Manths Days Hours DIVORCED WIDOWED 3/16/91 Male White TOB. KIND OF BUSINESS OR 12 CITIZEN OF WHAT 100. USUAL OCCUPATION (Give kind of work done 13 BIRTHPLACE (County & State or foreign country) COUNTRY? during mast of working life, propy if jet red) Retired
13. FATHERS NAME Alabama. ISA 14 MOTHER'S MAIDEN NAME Marston Fiske Galloway 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service) INFORMANT Address Unknown Hospital records burial, cremotion, 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))
PART I DEATH WAS CAUSED BY-INTERVAL BETWEEN signed by the burial-tronsit p ONSET AND DEATH Bronchopneumonia IMMEDIATE CAUSE (a). attending physician. DUE TO Conditions, if ony, which gave nse to immediate cause (a), DUE TO tor use os the t f Health prior to b stating the underlying couse O FUNERAL DIRECTOR: After this certificate has been PART IL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? NO V Chronic Brain Syndrome associated with Generalized Arteriosclerosis YES be retained by the hospitol or 205. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item IB.) 200 ACCIDENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20d INJURY OCCURRED 20e. PLACE OF INJURY (Hame, form, (City or town) (County) (Stote) TIME OF INJURY Month, Day, Year factory, street, office bldg, etc.) Not While at work at work 21. I certify that (I) (this haspital) attended the deceased fram 3/20/ , 19 67, that (1) (we) last 3/13/ \_, 19<u>67</u>\_, ta\_ 3/20/ 1967, and that death accurred all 0:10 M, fram causes and an the date stated above. saw the deceased alive an. 22b. DATE SIGNED 22a. SIGNATURE ATTENDING MED 3/21/67 X. director, page 3 should be filed w DIRECTOR PHYS. PHYS 22d. ADDRESS PHYSICIAN'S 22€ NAME (Type) Crownsville State Hospitalm Maryland Benedict, M.D. 23c NAME OF CEMETERY OR CREMATORY 230 BURIAL, CREMATION, 23d -LOCATION (City or Town) 23Ь DATE THEREOF (County) (State) REMOVAL (Specify) 2Sb. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR VR A15 (4) .\\ 20 M 1/■



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03044 CERTIFICATE OF DEATH death he law requires that the death certificate be executed within 24 hours after death sican and campletely filled in by the funeral please remave carban papers. Pages 1-and 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) . PLACE OF DEATH a COUNTY a. STATE **b** COUNTY hours ofter Anne Arundel
b CITY OR TOWN (If autside corporate limits, MARYLAND Marvland Anne Arundel CLENGTH OF STAY IN 16 ECITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) write RURAL and give negrest town) Glen Burnie Glen Burnie 45VTS. d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? YES T NO N 95 Glendale Ave 95 Glendale Ave 3 NAME OF Middle Last 4. DATE Manth Year DECEASED (Type or print) DEATH Flannerv Bernard March IF UNDER 24 HRS S SEX B DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR 6 COLOR OR RACE 7 MARRIED NEVER MARRIED last birthday) Months Days Hours White May 3.1892 WIDOWED DIVORCED 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT 10g JSUAL OCCUPATION (Give kind of work done 11 BIRTHPLACE (County & State, or fareign country) INDUSTRY COUNTRY? during most of working life, even if retired) Baltimore, maryland
14. MOTHER'S MAIDEN NAME Accountant Balto. Paint Co IISA 13 FATHER'S NAME Micheal J. Flannery Ella Gerlach 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO Address Same as (Yes no, or unknown) (If yes give war ar dates of service) 220-18-3614 Mrs. Dorothy A. Flannery (Mife) INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) burial-transit ONSET AND DEATH PART I, DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUF TO Conditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying cause far use as the l i Health priar to b TO FUNERAL DIRECTOR: After this certificate has been WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) NO YES . be retained by the haspital ar 205, DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20g ACCIDENT WAS UNDERLYING [7] OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or town) (County) (State) 20c TIME OF INJURY Manth, Day, Year factory, street, affice bldg . etc.) Haur a.m. Nat While at wark at wark 2-10-, 1967, that (1) (we) lost 2). I certify that (I) (this hospital) attended the deceased from. 1964 . to 19 67, and that death occurred at 10 PM, from causes and on the date stated above. saw the deceosed alive on 22a. SIGNATURE 22b DATE SIGNED ATTENDING DIRECTOR PHYS. M.D. 22d, ADDRESS 22c PHYSICIAN'S NAME (Type) Jar Jariad Je gannangia director, 23E NAME OF CEMETERY OR CREMATORY 23a BURIAL CREMATION. 23b. DATE THEREOF 23d. LOCATION (City or Town) REMOVAL (Specify) Cemetery Baltimore, Maryland New Cathedral March 4/67 Buria 24. FUNERAL DIRECTOR **ADDRESS** VR A15 (4) 20 M 1/66 Home Glen Aurnie, Md. Singleton Fungral DATE

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 23201 03042 CERTIFICATE OF DEATH death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a COUNTY o. STATE h. COUNTY ANN ARUNDEL event, within 72 haurs after MARYLAND ANN ARUNDEL The law requires that the death certificate be executed within 24 haurs after MARYLAND b. CITY OR TOWN (.f autside carparate ..mits, C LENGTH OF STAY IN 16 c CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) write RURAL and give nearest tawn) 07.1 PASADENA GLEN BURNTE filled in papers. d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? North Arundel Hospital NO FIR 22% BAR HARBOR ROAD YES Middle remove carban NAME OF First Last 4. DATE Day Year campletely DECEASED Danial E Follin 19 67 DEATH (Type or print) 5 SEX B. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS 6 COLOR OR RACE 7. MARRIED NEVER MARRIED 9. AGE (in years last b rthday) Months Hours Days WIDOWED DIVORCED 6/T/T9TT WHITE and in any MALE and 10a USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of warking life, even if retired) U.S.A. INDUSTRY physician in please BALTIMORE. MD. FLECTRICIAN 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME burial, crematian, or removal, CATHERINE BRENDLE JAMES E. FOLLIN 17 INFORMANT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. Address (Yes, na, or unknown) (If yes give war or dates at service) MRS GRACE FOLLIN 224BAR HARBOR RD. PASADENA INTERVAL BETWEEN CAUSE OF DEATH (Enter only one cause per line far (p), (b), and (c).) signed by the burial-transit p ONSEL AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) **O HOSPITAL OR ATTENDING PHYSICIAN:** The law requires the Page 4 may be retained by the hospital ar attending physician. DUE TO Conditions, if only, which gove rise to immediate cause (a). DUE TO stating the underlying couse **DIRECTOR:** After this certificate has been director, page 3 shauld be detached for use as the should be filed with the State Dept. af Health priar to last. 19 WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 222ml736 NO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 1B.) 20g ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Hame, form, (City or town) (County) (State) 20c. TIME OF INJURY Manth, Day, Year 20d INJURY OCCURRED factory, street, affice bldg, etc.) Nat While at wark 4.19/2 Ithat (1) (we) las 21. I certify that (1) (this haspital) attended the deceased fram Ahask and that death accurred at D. M. fram causes and an the date stated above saw the deceased alive an 3 220 SIGNATURE 22b DATE SIGNED ATTENDING PHYS DIRECTOR 22d. ADDRESS 22c PHYSICIAN'S FUNERAL NAME (Type) 23b DATE THEREOF 230. BURIAL CREMATION 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (State) MD. REMOVAL (Specify) GLEN BURNIE AA GLEN HAVEN CEMETERY 250 RECID BY REGISTRAR 1967 256 DEGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66 McCULLY F.H. 237 PATAPSCO AVE. BALTO. MD.

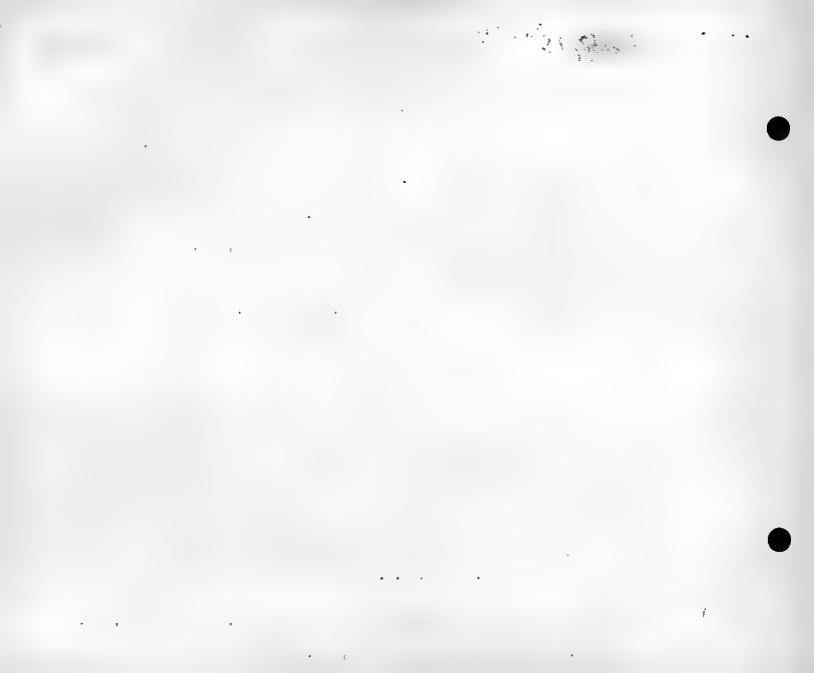
MARYLAND STATE DEPARTMENT OF HEALTH



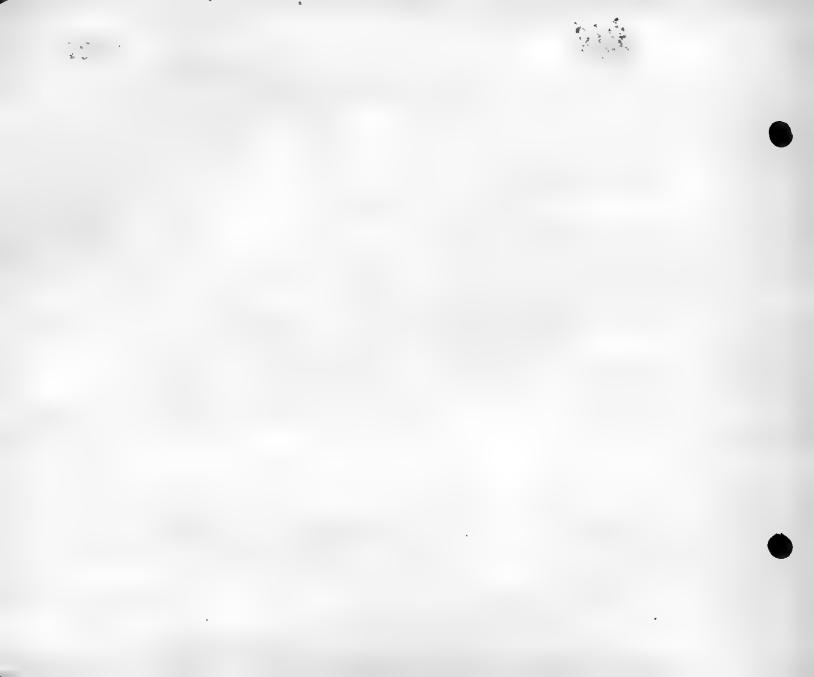
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03043 CERTIFICATE OF DEATH 03034 The law remuires that the death certificate be executed within 24 haurs after death. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) p. COUNTY. 6 COUNT MARYLAND OR TOWN (If outside corparate limits, c LENGTH OF STAY IN 16 c CITY OR TOWN (If autside carporate : mits, write RURAL and give nearest town) ban papers. Page, within 72 haurs a e Rural and give nedrest lawn) d NAME OF HOSPITAL OR INSTITUTION (If not in bospital, give street oddress) d STREET ADDRESS IS RESIDENCE ON A FARM? campletely filled NO. NAME OF remaye carban First Middle Last 4. DATE Manth DECEASED OF DEATH GARTLAND eyent, (Type or pant) SEX IF JNDER TYEAR 6 COLOR OR RACE 8. DATE OF BIRTH AGE (In years 7 MARRIED NEVER MARRIED Months Dovs EMALLE and in any WIDOWED DIVORCED gud 10b. KIND OF BUSINESS OR 10g USUAL OCCUPATION (Give kind of work done 12 CITIZEN OF WHAT 11 BIRTHPLACE (County & State, or fareign country) during mak of working life even if retired). HNDUSTRI physician 14. MOTHER'S MAIDEN NAME 13 FATHER'S NAM burial, crematian, ar remayal, en RG4-RET IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO INFORMAN3 (Yes, no. or unknown) (If yes give war or dates of service) 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN signed by the burial-transit p PART I. DEATH WAS CAUSED BY ANSET AND DEATH Congestive HeartFailure IMMEDIATE CAUSE (o)\_ **10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires the Page 4 may be retained by the haspital or attending physician. DUE TO Canditions, if any, which agre Hypertensive Cardio=Vascular Disease rise to immediate cause (a), DUE TO stoting the underlying cause prior to l the last. SD 19 WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) be detached far use State Dept, of Health Calculi Kidnev NO XX certificate 20g ACCIDENT WAS LINDERLYING [ 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 18 of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Doy, Year Haur o.m. 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, farm, (City or town) (County) (State) factory, street, affice blda, etc.) Not While of work TO FUNERAL DIRECTOR: After 21. I certify that (1) (this haspital) attended the deceased from Nov. , 1964 , to Mar. , 19 6 7 that (1) (we) last 1967, and that death accurred at 12:30 M, from causes and on the date stated above saw the deceased alive an Mar 22a. SIGNATURE 22b DATE SIGNED DIRECTOR M.D. 3-15-67 PHYS. director, page should be filed ADDRESS Park, Md. 22c PHYSICIAN'S 22d NAME (Type) Francis I. Codd M.D. DATE THEREOF NAME OF CEMETERY OR CREMATORY BURIAL, CREMATION 23d LOCATION (City or Town) (Couply) (State) RMOVAL (Specify) PONERAL DIRECTOR 2Sq. REC'D BY REGISTRAR 2Sb REGISTRAR'S SIGNATURE ADDRESS VR A15 (4) 25M 1/67



| I  | te            | ems 18&21 Film 338 4-25 MARYLAND STATE DEPARTMENT OF HEALTH  |                                     |
|--|---------------|--|-------------------------------------|
| FOR STATE  |               | O3044 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 0304   | 35                                  |
| HEALTH DEPT.   | 1             | PLACE OF DEATH  o COUNTY Anne Arundel County, MARYLAND  2 USUAL RESIDENCE (Where deceosed lived, if institution Residence before o. STATE b. COUNTY Anne Aru   | odmission)                          |
| f any delay, is<br>T, 2, and 3 to<br>m PM3. Page   |               | b CITY OR TOWN (f outside corporate limits, write RURAL and give nearest town)  c. LENGTH OF STAY IN 1b  c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  Glen Burnie   | town)                               |
| orm P. 2, 2, 2, 2, 2, 2, 2, 2, 2, 2, 2, 2, 2,  |               | d. NAME OF HOSPITA. DR INST TUTION (If not in hospital, give street oddress)  North Appe Amindel Hospital  | IS RESIDENCE<br>DN A FARM?<br>FS NO |
| after deoth If 68. Give Pages 1, along with form with the Stote De   | 3             | NAME OF First Middle Lost 4 DATE Month Doy OF Greated OF DEATH March 18  | Year<br>19 67                       |
| 24 hours after death. If an I fee I fee I fee I fee I fee I fee I form is Office along with form es I ond 2 with the State Death.  | S             |  | Hours Min.                          |
| 24 hours<br>in Item 18<br>r's Office<br>es Tond 2 v  | 10d<br>dui    | 00 USUAL OCCUPATION (Give kind of work done uring most of working life, even if retired)  10 KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country)  11 COUNTRY?  COUNTRY?  LISA  | WHAT                                |
| executed within 2<br>ending" in pencil<br>f Medicol Examiner<br>it permit. File page:<br>t within 72 hours af  | 13.           | 3. FATHER'S NAME 14 MOTHER'S MAIDEN NAME (Unknown)   |                                     |
| cuted vinding in dicel Extra from 72 fine 72 f | IS<br>(Y      | S. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give wor or dates of service) No None (Unknown) Mr. Lilliam R. George (Son) Same   | = #2                                |
| word "p<br>the Chie<br>rial frons  |               | 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b) and (c),)  | RVAL BETWEEN<br>T AND DEATH         |
| INER: This certificate since the certificate, writing the should be forworded to files.  3 should be used as a buttan, or remaval, and in contact.   | ATION         | PART I OTHER SIGNIFICANT CONDITIONS CONTRIBITING TO DEATH BIT NOT DE ATEL TO THE LERWING TO SEASE CONDITION GIVEN IN PART 1(c)   | VAS AUTOPSY<br>PERFORMED?           |
| # _ P _  | CERT FICATION |  | <u> </u>                            |
| EXAMINER: cute the certificate of should ryaur files. Poge 3 should cremation, or  | MEDICAL       | 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED While of work  | (State)                             |
| TCAL TOTAL T |               | death resulted fram. Natural causes 🖺 , Accident 🗍 , Suicide 🗍 , Homicide 🗍 , Undetermined monner 🗍  | in my opinion                       |
| TO DEPUTY MEDIC<br>necessary, please e<br>the funerol director<br>5 moy be retained<br>TO FUNERAL DIRECT<br>Health prior to bur  |               | ACTUAL SIGNATURE  SIGNATURE  EXAMINER'S  NAME (Type)  ASSISTANT MED CAL EXAMINER  DEPUTY MED CAL EXAM NER  Address (Street, city, town, or county)   | ,1967                               |
| TO D<br>nece<br>the<br>5 m<br>TO FU<br>Heol  | 23            | 30 BUR AL CREMATON, REMOVAL (Specify)  BUTIEL  236 DATE THEREOF  23c NAME OF CEMETERY OR CREMATORY  BUTIEL  23d LOCAT ON (City or Town) (County)  March 21,1967 Glan Haven Memorial Pk. Glan Burnia, Md.   | (Stote)                             |
| VR A15ME (5)   | ١             | 24. FUNERAL DIRECTOR  ADDRESS  ADDRESS  250 RECT BY REGISTRAR 250 REG STRARS SIGNATURE RICHARD V. Singleton  Glan Burnia. Md.  MAR 2 3 1967  ADDRESS  ADDRES | ge.                                 |



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death. and PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY o. STATE b. COUNTY Anne Arundel MARYLAND Maryland C LENGTH OF STAY IN 15 c CITY OR TOWN (If outside comorate limits, write RURAL and give negrest town) b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville 9 days Baltimore carbon papers. d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e IS RESIDENCE ON A FARM? d. STREET ADDRESS YES NO IX Favette Street Crownsville State Hospital 3 NAME OF Midd e 4 DATE Year Lost Doy attending physicion and completely, sermit. Then please remove carbon DECEASED (Type or print) #34863 19 67 Gibson DEATH Carl IF UNDER 24 HRS. 9 AGE (In years IF UNDER 1 YEAR 5. SEX 8. DATE OF BIRTH 6 COLOR OR RACE 7 MARRIED NEVER MARRIED V lost birthdoy) Months Doys Hours WIDOWED DIVORCED 2/7/26 Male White 100 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 12. CIT ZEN OF WHAT 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) COUNTRY? INDUSTRY Bartender
13. FATHER'S NAME USA Tennessee. 14 MOTHER'S MAIDEN NAME Annie Ed Gibson 17. INFORMANT Address 15 WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) ((If yes give wor or dates of service) 16. SOCIAL SECURITY NO. Hospital Records Yes Unknown cremotion, 18 CAUSE OF DEATH (Enter only one cause per one for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY. INTERVAL BETWEEN the signed by the buriol-transit p buriol, cremoti ONSET AND DEATH Bronchopneumonia IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gave Chronic Alcoholism rise to immediate couse (o), DUE TO aftending tor use as the t Health prior to b stating the underlying couse hos been 19. WAS AJTOPSY PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) YES [ NO [ TO FUNERAL DIRECTOR: After this certificate ģ 205. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Port I or Port II of item 18.) 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Not While foctory, street, office bldg., etc.) of work ot work 3/21/, 19 67, that (I) (we) last 21. I certify that (I) (this haspital) attended the deceased fram , 19, 67, ta be retoined 1967, and that death accurred at 12:50, fram causes and an the date stated above. saw the deceased alive on 22b. DATE SIGNED 220. SIGNATURE **ATTENDING** STAFF PHYS. 3/21/67 DIRECTOR director, page 3 should be filed v M.D. 22d. ADDRESS TO HOSPITAL (Poge 4 moy b 22c. PHYSICIAN'S NAME (Type) Crownsville State Hospital, Maryland Benedict. M.D. 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 230 BUR AL CREMATION. 23b. DATE THEREOF (County) (Stote) REMOVAL (Specify) ELLICO ) ELLICO ENNESSEE 3-25-67 EMETERY REGISTRAR'S SIGNATURE MUNERAL DIRECTOR ADDRESS 2So. REC'D BY REGISTRAR 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03046 03037 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY o. STATE b. COUNTY filled in by the fun popers. Pages 1 thin 72 haurs after a Anne Arundel MARYLAND Marvland Anne Arundel b CITY OR TOWN (If autside corparate limits, write RURAL and give nearest town) c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b Annapolis D.O.A. RURAL - Annapolis d NAME OF HOSPITA. OR INSTITUTION (If not in hospital, give street address)
(Dead on arrival)
Anne Arundel General Hospital d STREET ADDRESS IS RESIDENCE ON A FARM? 31 Bay Drive, Bay Ridge YES NO XX Sol Middle 4 DATE OF DEATH 3. NAME OF campletely layer Bernard Day Year Goldstein DECEASED 19 67 (Type or print) Bernard Sol MERELMAN March F UNDER I YEAR 9. AGE (In years IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH ev last birthday) Manths Davs Haurs June 22, 1892 and in any Male White WIDOWED DIVORCED and 10a, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY S. Govit COUNTRY? ret, accountant New York 13. FATHER'S NAME 14, MOTHER'S MAIDEN NAME signed by the attending physi burial-transit permit. Then pl burial, crematian, or remaval, Israel Merelman Emma Eisler 17 INFORMANT 11 Stehle Stress 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 36 SOCIAL SECURITY NO. (Yes, no, ar unknown) (if yes give war at dates of service Bernard Legum Annapolis, Maryland none INTERVAL BETWEEN ONSET AND DEATH IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) )
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) by the haspital ar attending physician. DUE TO Conditions of only, which gave rise to immediate cause (a), DUE TO ficate has been s far use as the b Health priar ta b stating the underlying cause fast. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) MAS AUTOPSY PERFORMED? NO XX 20g ACCIDENT WAS UNDERLYING [1] 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Part 1, of item 18.) OR CONTRIBUTING I CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e, PLACE OF INJURY (Hame, form, 20f. (City or town) (State) 20c. TIME Of INJURY Month, Day, Year (County) Hour a.m. factory, street, office bldg., etc.) at wark at wark TO FUNERAL DIRECTOR: After Marcela, 1962, that (1) (we) last 21. I certify that (1) (this bassip) attended the deceased from, 19.60\_, ta. M fram causes and an the date stated above Page 4 may be retained director, page 3 should should be filed with the saw the deceased alive an 10. 10 19 . and that death accurred a 22a SIGNATURE 22b DATE SIGNED ATTENDING STAFF PHYS M.D DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) John L. Hedeman. M.D. 1407 Forest Drive, Annapolis, Md. 230. BURIAL, CREMATION, Burial 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23b DATE THEREOF (State) Mar. 26.1967 Adas Israel Cemetery Washington 24 Beverley E. Hopping Hopping Funeral Home 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATUR VR A15 (III) Annapolis/ Maryl



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs

VR A15 (4) 20 M 1/66

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

| 03047  | CERTIFICATE                    | OF DEATH                                |   | 03038  |
|--|--------------------------------|---|---|--|
| 1 PLACE OF DEATH   |                                |   | Vhere deceosed lived, if institution                  |  |
| a. COUNTY Anne Arundel   | MARYLAND                       | o. STATE<br>Ma.ry                       | b. coun   | IT   |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)        | c LENGTH OF STAY IN 16         |   | tside corparate limits, write RUR.                    | AL and give nearest town)                    |
|  | 20                             | Dalles                                  | more  | 2. 1   |
| Crowns ville  d NAME OF HOSPITAL OR INSTITUTION (If not in hospitol,                   | 1 30 years                     | d STREET ADDRESS                        | lilore  | e IS RESIDENCE                               |
|  |                                |   |   | ON A FARM? YES NO NO                         |
| Crownsville State Hospi  |                                | Unkno                                   |   |  |
| 3. NAME OF First DECEASED  | Middle                         | Lost                                    | 4 DATE Month OF                                       |  |
| (Type or print) #05301 Annie   |                                | Gray                                    | DEATH 3   | 15. 167<br>IF UNDER 1 YEAR 11F UNDER 24 HRS. |
| S SEX 6 COLOR OR RACE 7, MARRIED   |                                | B. DATE OF BIRTH                        | 9 AGE (In years last birthday)                        | Months Doys Hours Min.                       |
| Female Negro WIDOWED   |                                | -/-/77                                  | 90 yrs.   |  |
|  | (IND OF BUSINESS OR<br>NDUSTRY | 11 BIRTHPLACE (County                   | & State, or fareign country)                          | 12 CIT ZEN OF WHAT<br>COUNTRY?               |
| Domestic   |                                | Unknov                                  | m   | USA  |
| 13 FATHER'S NAME   |                                | 14. MOTHER'S MAIDEN                     | VAME  |  |
| Unknwn   |                                | Unknown                                 |   |  |
|  | SOCIAL SECURITY NO 17          | INFORMANT                               | Addres  | 35   |
|  | known                          | Unemitel I                              | 2000000000  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for                                   |                                | Hospital_E                              | eroros  | INTERVAL BETWEEN                             |
|  | monia . Conges                 | tivo Hoort 1                            | Foilumo   | ONSET AND DEATH                              |
| 443 X DUE TO   | miotita * cottRes              | CIVE HEALC                              | alluie  |  |
| 1 10 101   |                                | 2 1                                     |   |  |
| nse to immediate cause (a),  | ertensive Cardi                | ovasciilar D                            | sease   |  |
| stoting the underlying couse (   |                                |   |   |  |
| lost. (c)  |                                |   |   | 19 WAS AJTOPSY                               |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING                                     |                                |   |   | PERFORMED?                                   |
| Chronic Brain Syndrome   | secondary Cereb                | ral Arterio                             | sclerosis   | YES NO X                                     |
| 205 D  205 D  205 D  205 D   | ESCRIBE HOW INJURY OCCURRED    | (Enter noture of injury in              | Part I or Port II of item 18.)                        |  |
| (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                |   |   |  |
|  |                                | CE OF INJURY (Home, forn                |   | (County) (State)                             |
| Hour a.m. 19 White of wo   | e Nat While of work            | tary, street, affice bldg , etc.        |   |  |
| 21 I certify that (I) (this haspital) after  |                                | 5/3/                                    | 9.37, ta 3/1  | .5/, 19 <u>67</u> , that (I) (we) las        |
| saw the deceased alive/on3/15  | /19 <u>67</u> , and tha        | it death accurred at                    | : 30A M, fram causes of                               | and an the date stated above                 |
|  |                                |   | 11F0  | 22b. DATE SIGNED                             |
|  | 7 (                            | D. PHYS                                 | MED. STAFF DIRECTOR DIRECTOR PHYS.                    | 3/21/67                                      |
| 220 SIGNATURE MILLEURIS  | M.                             | .D. PHYS 🗀                              | DIRECTOR GO FITTS. C                                  |  |
| . 22c. PHYSICIAN'S   | -                              | 22d. ADDRESS                            | DIRECTOR SE FILIS.                                    | 71_3/21/01                                   |
|  | -                              | 22d. ADDRESS                            | Le State Hospi  |  |
| 22c. PHYSICIAN'S NAME(Type) L. Benedict, M.I   | ). /                           | 22d. ADDRESS<br>Crownsvil               | 21  | tal, Maryland                                |
| 22c. PHYSICIAN'S NAME(Type) L. Benedict, M.I  23o. BURIAL CREMATION, 23b. DATE THEREOF | -                              | 22d. ADDRESS<br>Crownsvil               | Le State Hospi  | tal, Maryland                                |
| 22c. PHYSICIAN'S NAME (Type) L. Benedict, M.I  | ). /                           | 22d. ADDRESS<br>Crownsvil.<br>CREMATORY | Le State Hospi  23d. LOCATION (City or low  Balfimore | tal, Maryland                                |



| - TO TO  |       | DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  CERTIFICATE OF DEATH  03039  |
|--|-------|--|
| 4 hours after by the funer and 2 shouldeath.   | M     | t. PLACE OF DEATH a. COUNTY  Anne Arundel  b. CITY OR TOWN (f outs de corporete limits, write RURAL and give necesst town)  c. LENGTH OF STAY IN 16  c. CITY OR TOWN (If outside corporete limits, write RURAL and give necesst town)  |
| cate be executed with 2 ian and completely the line in section papers. Pages 1 ivent, within 72 hours after.   | J     | Pasadena d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress)  Bex 169, Rt. 11 3. NAME OF DECEASED (Type or print)  JESSIE GERALDINE GUTBERIET  5. SEX  6. COLOR OR RACE 7. MARRIED NEVER MARRIED S. DATE OF BIRTH  Wilder Month Dey  Yes No Pasadena  d. STREET ADDRESS  Bex 169, Rt. 11  DATE OF BIRTH  OF DEATH  9. AGE (In yeers If UNDER 1 YEAR HOURS AND IN SETTING AND IN SET IN SETTING AND IN SET IN  |
| aquires that the death certiff hysician. In the attending physic ned by the attending physic sit permit. Then please remoin or removal, and in any e |       | Housewife  Springfield, III.  13. FATHER'S NAME  Clifford W. Stone  14. MOTHER'S MAIDEN NAME  Clifford W. Stone  15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT  Address  No.  18. CRUSE OF DEATH [Enter only one couse per I no for [e], (b), end (c),  PART I. DEATH WAS CAUSED 8Y:  IMMEDIATE CAUSE (a) ACUTE MYD CARD IAL TNFARCTION  DUE TO  |
| PHYSICIAN; The law re the hospital or attending prise certificate has been sig for use as the burial-trans the prior to burial, crematic             |       | Conditions, if eny, which gave rise to immediate cause (a), stating the underlying of the performance of the |
| AL CE ATTENDING 18 4 1 2 2 CTOR: After the State Dept. of Health   |       | 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, ferm, 20f. (Cty or lown) (Stele)  While at work at work 21 certify that (I) (this hospital) attended the deceased from 1960 ST, 1968, to F.E.D, 1967, that (I) (we) lass saw the deceased alive on F.E.D. 2.1  |
| TO HOSPITA  WAS death. Page WEST D FUNERA  OF GIFT DESCRIPTION  (b) be filed with  | A. C. | 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OF CREMATORY REMOVAL (Specify)  Burial Mar. 20,1967  Baltimore National Cem. Baltimore, Maryland Address George J. Gonce-4001 Ritchie Hawy., Baltimore  MAR 2 1 1967  MAR 2 1 1967   |

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 EXAMINER'S CERTIFICATE OF DEATH 03040 FOR STATE HEALTH DEPT. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased aved, if institution Residence before admission) o. COUNTY o. STATEMaryland b. COUNTY Anne Arundel 2, and 3 ta PM3 Page Anne Arundel MARYLAND y delay b. CITY OR TOWN (If gutside corporate limits. E LENGTH OF STAY IN 16 c CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) Glen Burnie Tand 2 with the State Depost d NAME OF HOSPITAL OR INSTITUTION (If not in hospitor, give street address) d STREET ADDRESS e. IS RESIDENCE ON A FARM? ie certificate, writing the word "panding" in pencil in Item 18. Give Pages 1, 's should be farwarded to the Ch ef Medical Examiner's Office along with form 360 Gaylor Rd. be executed within 24 haurs after death. If North Arundel Hospital YES NO [ NAME OF Eirst Middle 4 DATE Last Month Year DECEASED OF DEATH BURNARD HAMLETTA March 25 ,9 67 (Type or print) IF UNDER 1 YEAR | 1F UNDER 24 HRS 6 COLOR OR RACE 7 MARRIED NEVER MARRIED DATE OF BIRTH AGE (In years lost bythdoy) Months death. Male Negro W DOWED TO DIVORCED 100 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR BIRTHPLACE (State of foreign country) 12 CT ZEN OF WHAT during most of working life, expirit retired) INDUSTRY 13. FATHER'S NAM 14. MOTHER'S MAIDEN NAME event with n 72 haurs 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMA (Yes, no, or unknown) (If yes give wor or dates of service INTERVAL BETWEEN 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c)) PART I DEATH WAS CAUSED BY: ONSET AND DEATH Acute ethylism IMMEDIATE CAUSE (o) ". ddU DUE TO any Conditions, if ony, which gove rise to immediate couse (a). Ξ DUE TO stating the underlying couse lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBLYING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART ITO). 19 WAS AUTOPSY PERFORMED? remayal, CERTIFICATION YES [X] NO 20o EXTERNAL CAUSE WAS 20b DESCR 8E HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18.) 3 shauld PRIMARY Or CONTRIBUTING crematian, ar CAUSE OF DEATH MEDICAL 20d NJURY OCCURRED 20e PLACE OF INJURY (Home form, (City or town) 20c T ME OF INJURY Month, Doy, Year (County) (Stots) Hour o.m factory, street, office bldg, etc.) Not While of work at work Partial 21 I certify that I taak charge of the remains described above, held an Autopsy X Inspect on . Inquiry and in my opinion Suicide death resulted from Natural causes X Accident [ Hamicide | Undetermined manner the funeral director CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER X SIGNATURE FUNERAL Health priar þę DEPUTY MEDICAL EXAMINER 3-25-67 Charles S. Springate, M.D. **EXAMINER'S** Address (Street, city, town, or county) NAME (Type) 23o BURIAL CREMATION. 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATOR 23d LOCATION (City or Town) (Stote) 0 2So. REC'D BY REGISTRAR EUNERAL DIRECTOR 25b. VR A15ME (5) 6M 1/67

j.

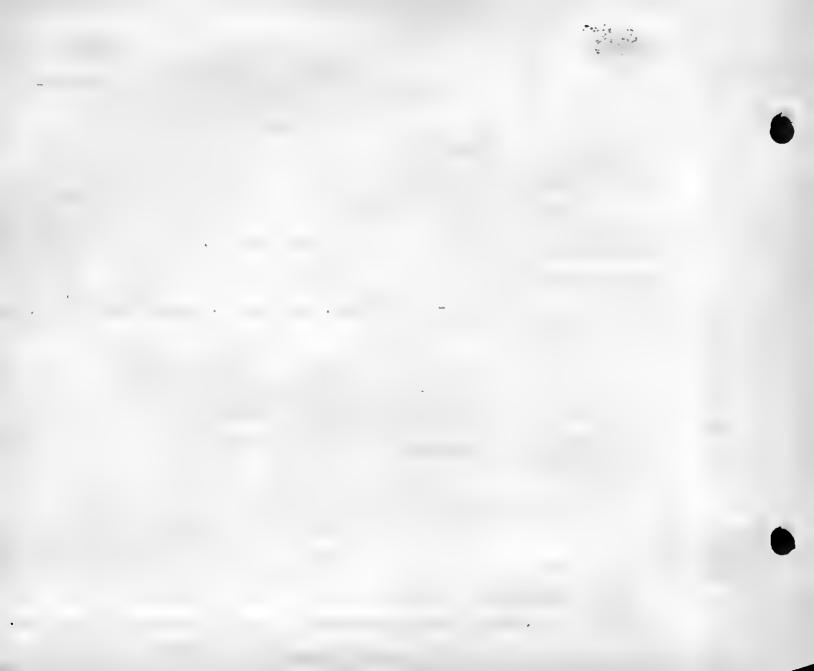
| X   | 1  | 1             | Division of STATISTICA   |              | MARYLAND STATE DE<br>ARCH AND RECORDS, 30' |                                 |                  | MORE, MARYL                       | AND 21201                  |                                   |
|---|--|---------------|--|--------------|--|---------------------------------|------------------|-----------------------------------|----------------------------|-----------------------------------|
|   | 2 -  |               | 03050  |              | CERTIFICATE                                | OF DEATH                        |                  |                                   | 03                         | 041                               |
| t pa  | and 2  | 1.            | PLACE OF DEATH   |              |  | 2. USUAL RESIDENCE (            | Where deceas     |                                   |                            | ire odmissian)                    |
| OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death refrired by the hamited as extended within 24 haurs after death |  |               | Anne Arunde  | 1            | MARYLAND                                   |                                 | ryland           |                                   | AnneAr                     |                                   |
| S of  | the age in   |               | CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)                |              | C LENGTH OF STAY IN 16                     | c CITY OR TOWN (IF or           |                  |                                   | AL and give neare          | st town)                          |
| la Br   | in by<br>irs. P<br>2 hau   | $\vdash$      | Annapolis  I NAME OF HOSPITAL OR INSTITUTION (If not in                                      | hospital     | 1 mo. 1 da.                                | RURAL -                         | Anna             | 00115                             | ٠ ٠ ٠                      | e IS RESIDENCE                    |
| 24  | aper<br>n 72   |               | nne Arundel General I  |              | -  | Rt-2, Box                       | -405             |                                   |                            | ON A FARM? YES NO NO              |
| ig.   |  | 3             | NAME OF First  | .000         | Middle                                     | rast                            | 4. DATE          | Mant                              | n Do                       |                                   |
| ``≅   | campletely filled<br>nave carbon pape<br>y event, within 7.  |               | PECEASED Type or prof)  Amelia   |              | Minnie                                     | HARRIS                          | OF<br>DEATH      | March                             | 3                          | 1967                              |
| utec  | ve c   | 5             | 6. COLOR OR RACE 7.  | MARRIED      |  | B. DATE OF BIRTH                |                  | . AGE (In years<br>Jast birthdoy) | F UNDER 1 YEAR Months Days | IF UNDER 24 HRS.<br>Hours Min.    |
| exe   | and ca<br>rema<br>in any   |               | 1 01110FT  | VIDOWED      |  | Aug. 25, 19                     |                  | 66 yrs.                           |                            |                                   |
| 20  | cian and campletely filled in<br>base remave carbon papers.<br>ghd in any event, within 72 h   | 10a<br>duji   | US_AL OCCUPATION (G ve kind of work done )   |              | IND OF BUSINESS OR<br>Noustry              | 11 BIRTHPLACE (County           | & State, ar to   | reign country)<br>Marylan         | 12. CITIZEN O              | P WHAT                            |
| cate  | Sicion Sign  | 13.           | FATHER'S NAME  | 4            | -/-  | 14 MOPHERS MAIDEN               | NAME             | rarytan                           | u 0.5.                     |                                   |
| ertif   | p ysician o  |               | Weenge a   | Va           | ited                                       | ( SIL                           | 100              | ton                               | WL                         | 921                               |
| 듄   | attending  <br>permit. The<br>an, ar remo  | 15.           | WAS DECEASED EVER IN U.S. ARMED FORCES? (s, no, or unknown) (If yes give wor ar dotes af ser | 16           | SOCIAL SECURITY NO.                        | MPORMANT                        | 0 0              | //// Addre                        | 55                         | 11/1                              |
| dec   | attendii<br>permit.<br>ian, ar re  | (10           |  |              | 11/-                                       | Wand                            | DIL              | llay,                             | your                       | ACINIKY.                          |
| the   |  |               | 18. CAUSE OF DEATH (Enter only one couse po<br>PART I, DEATH WAS CAUSED BY                   | er line far  | (a) (b) and (c))                           | rs.                             |                  |                                   | IN O                       | ITERVAL BETWEEN<br>NSET AND DEATH |
| ± fa  | priyaktur.<br>signed by the<br>burial-transit<br>burial, cremat  |               | IMMEDIATE CAUSE (a)  |              | 21   | <u> </u>                        |                  |                                   |                            |                                   |
| ires  | signed by<br>burial-tran<br>burial, cren   |               | Canditians, if any, which gave ) (h)   | 0            | carever 1                                  | Deval ?                         | Zen              | earl                              |                            |                                   |
| The law requires th   | S 6 8 9 9  |               | rise to immediate couse (a), DUE TO  | 91           | ypulinum                                   | Euroles                         | Var              | way D                             | was                        |                                   |
| aw D  | s the  |               | last.  |              | //   |                                 |                  |                                   |                            | <u> </u>                          |
| The   | After this certificate has been to be detached for use as the State Dept. of Health priar to   | NO            | PART II. OTHER SIGNIFICANT CONDITIONS CONTR  | RIBUTING     | TO DEATH BUT NOT RELATED TO                | THE TERMINAL DISEASE CO         | NDITION GIVE     | N IN PART 1(o)                    | 19                         | PERFORMED?                        |
| ÿ.Š   | e affi   | FICAT         | 20o ACCIDENT WAS UNDERLYING  | 205 DI       | ESCRIBE HOW INJURY OCCURRED                | finter nature of injury in      | Port Lor Por     | t II of item 183                  |                            | YES NO 🗵                          |
| SICI/   | office of the  | CERTIFICATION | OR CONTRIBUTING (I CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                       | 200. 0       | ESCRIPT HOW HOOK? OCCURRED                 | true notate or infat in         | 1011 1 01 101    | 11 01 110111 10.7                 |                            |                                   |
| PHY   | is ce<br>tach<br>Dept.   | MEDICAL       | 20c TIME OF INJURY Month, Doy, Year  |              |  | CE OF INJURY (Hame, farm        |                  | (City or town)                    | (County)                   | (Stote)                           |
| 5 5   | er the   | WEI           | p.m., 19   | While at war |  | ory, street, office bldg , etc. | 4                |                                   |                            |                                   |
| I QN  | d be St  |               | 21. I certify that (I) (thesebosoic  | l) atten     | ided the deceased from                     | -1-1-3,                         |                  | o_Mar. 3                          | 19_671                     | that (I) (see las                 |
| E E   | 20 E   | Н             | saw the deceased affive onMe   | ar.          | 3,19_67, ond tho                           |                                 |                  | I, from couses                    | and on the da              | ate stated obove                  |
| OR ATTENDING PHYSICIAL  | dwis   |               | and the  | -            | M.I  | ATTENDING PHYS.                 | MED.<br>DIRECTOR | STAFF PHYS.                       | 3-7                        | 7-61                              |
| AL C  | file of  |               | 22c. PHYSICIAN'S NAME (Type)   | - 1          | LLEBU                                      | 22d. ADDRESS                    |                  |                                   | 3                          | 6.3                               |
| SPIT  | d be   |               |  | -            | 17.90                                      |                                 |                  | St., Anna                         |                            | id.                               |
| TO HOSPITAL   | O FUNERAL DIRECTOR: After this certificate has been director, page 3 should be detached far use as the should be filed with the State Dept. of Health priar to | 230           | REMOVAL (Specify) 23b DATE THEREO  | ar-          | 23c NAME OF CEMETERY OR                    | DO B                            | 23d 10           | PAT ON CON ar Tov                 | vn) (Caunh                 | y) / Storey                       |
| 00  | - E ( )  | 24            | FUNERAL DIRECTOR   | 101          | ADDRESS                                    | 11 /250. REC                    | D BY REGISTR     | CAR 25b. REG                      | GUSTRAR'S SIGNATU          | JRE -                             |
|   | VR A15 (4).<br>20 M 1/66   | 1//           | 1/1 cleam Relea  | 10#          | Maria                                      | VIICO DAMAI                     | 7 6              | 1967 80                           | lianter S                  | week                              |
|   |  | 44            | <del></del>  |              |  | 7                               |                  |                                   | - 1                        | 0 .                               |



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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 03051 requires that the death certificate be executed within 24 haurs after death the funeral and PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution a. COUNTY o STATE **b** COUNTY MARYLAND ELENGTH OF STAY IN 16 b CITY OR TOWN (If outside corporate limits, c CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town e RURAL and give negrest, town) Beach 1 ik by NAME OF HOSPITA. OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? Filled YES NO X Middle NAME OF First Last 4 DATE Manth Dov Year campletely DECEASED 2344 6. 19 (Type or print) DEATH IF JNDER 1 YEAR SEX AGF (In years IF JNDER 24 HRS. 6 COLOR OR RACE 7, MARRIED THEYER MARRIED DATE OF BIRTH last birthday) Months Days Hours in any 6. 25.30 WIDOWED DIVORCED and 10a. USUAL OCCUPATION (Give kind of work dane 10b, KIND OF BUSINESS OR 11 BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT COUNTRY? USA during most of working life, even if retired) INDUSTRY Washington, D. C. Plumber
13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME crematian, ar removal, Marguerite Zennes Ellery Maynes 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16 SOCIAL SECURITY NO 73rd Place (Yes, na, ar unknawn) (If yes give war ar dates of service) 216-22-1255 Mrs. Elizabeth D. Maynes Kent Village, Mi INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per une far (a), (b), and (c).) ONSET AND DEATH burial-transit PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave use to immediate cause (a). DUE TO stating the underlying cause has been the last. WAS AUTOPS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) PERFORMED? YES NO O FUNERAL DIRECTOR: After this certificate fa 20a ACC DENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b, DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part | or Part || of item 18.) etached (IF EITHER, NOTIFY MEDICAL EXAMINER (City or town) 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (County) (State) Haur o m. Not While foctory, street, affice blda., etc.) at work at wark 21. I certify that M (this haspital), attended the deceased from 19\_\_\_, that (I) (we) last and that death accurred at M, fram causes and an the date stated above saw the deceased alive an. 22b. DATE SIGNED 22a SIGNATURE M.D. PHYS. DIRECTOR 22d ADDRESS 22c PHYSICIAN'S BENEDICT NAME (Type) director shauld 23d. LOCATION (City or Town) 23a. BURIAL, CREMATION 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) (Stote) REMOVAL (Specify)
Burial Southern Memorial Gardens Mar.15.1967 Dunkirk Calvert Md. 25b REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR REC'D BY REGISTRAR VR A15 (4) Owings, MarylandWAR 20 M 1/66 unella



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03052 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) PLACE OF DEATH c COLINTY b. COUNTY MARYLAND the State Department CLENGTH OF STAY IN 16 TOWN (If outside corporate im ts wate RJRAL and give nearest town) de S RESIDENCE ON A FARM? OR INSTITUTION (If not in haspital, give street address) d STREFT NO 😾 in penal in Item 18 Give Pages along with NAME OF FIEST Middle DATE Manth Day DECEASED (Type or print) DEATH S SEX 6 COLOR OR RACE 9 AGE (In years F UNDER 1 YEAR 7 MARRIED NEVER MARRIED birthday) Manths Davs Hours event within 72 haurs after death W DOWED DIVORCED Office ( and 10g USUA, OCCUPATION (Give kind of work done 1Db KIND OF BUSINESS OR 12 CITIZEN OF WHAT INDUSTRY RU COUNTRY? certificate, writing the ward "pending" in penal in auld be farwarded to the Chief Medical Examiners 13 FATHER'S NAME MOTHER'S MAIDEN NAME WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMANT 16 SOCIAL SECURITY NO (Yes, no, or unknown) (If yes a ve war ar dates of service) 18 CAUSE OF DEATH (Enter only one couse per line for INTERVAL BETWEEN ET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO in any Conditions, if any, which cove nse to immediate cause (a), DUE TO stating the underlying cause SD used removal, 19 WAS AUTOPSY PERFORMED? PART II OTHER'S GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) NO D 2Do EXTERNAL CAUSE WAS 2Db DESCRIBE MOW INJURY OCCURRED (Enter nature of injury in Port I a. Part I of tem 18) 3 should ö PRIMARY OF CONTRIBUTING CAUSE OF DEATH. cremation, 2Dd INJURY OCCURRED 20e PLACE OF N.URY (Hame, farm, 20f (City or town) 2Dc T ME OF NJURY Month, Doy, Year ((ounty) (Stote) Hour am. factory, street, office bldg., etc.) Not While may be retained far your FUNERAL DIRECTOR: Page at work 21. I certify that Litook charge of the remaps described above, held on Autopsy Inspection and in my opinion deoth resulted from Notúral couses 🖊 Accident Suicide Homic de Undetermined monner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER prior SIGNATURE DEPUTY MEDICAL EXAMINER **EXAMINER'S** Health NAME (Type) Address (Street city town or county) 230 BUR AL CREMATION 0 250 REC D BY REGISTRAR 25b REGISTRARS FK. NERA. VR ATSME (ST 6M 1, 67



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 03053 **CERTIFICATE OF DEATH** Reg. Dist. No. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution, flesidence/before admission) o. COUNT **b.** COUNTY b. SITT OR JOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR JOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest lown) d. NAME OF HOSPITAL (If not in hospital, give street oddress) d STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO NAME OF Middle 4. DATE First Month Year OF DEATH (Type or print) 19 SEX 6. COLOR OR MACE 9. AGE (In years MARRIED NEVER MARRIED IF UNDER 1 YEAR IF UNDER 24 HRS lost birthdoy) Months Dovs Hours WIDOWED [7] DIVORCED | popers. 10g. USUAL QCCUPATION (Give kind of work done 10b. KIND OF AUSINESS OR INDUSTRY 11, BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT-COUNTRY during plost-of sperking life, even if retired) 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO Address IB. CAUSE OF DEATH [Enter only one couse per line for (o) (b), and (c) INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY-IMMEDIATE CAUSE (0) SUDDEN Conditions, if ony, which ) gove rise to immediate **DUE TO** couse (o), stoting the underlying couse fast PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19 WAS AUTOPSY PERFORMED? YES 🗍 NO 💢 200. ACCIDENT WAS UNDERLYING TO OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Part I or Port II of item 18.) 20c. TIME OF INJURY Month. 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20f (City or town) Doy, Year (County) (Stole) foctory, street, office bldg , etc.) 0. m. While Not white of work ot work ... 1960, to MARCH ... 1967, that I lost sow the deceased 21. I certify that I attended the deceased from APRIL and that death occurred at 300 M, from the causes and on the date stated above. oc\_0 ADDRESS (Street, city or town, state) DATE SIGNED 3-12-67 ARTHUR LANKFORD, JR., M. C. 2934 MOUNTAIN ROAD PHYSICIAN'S NAME (Type) TO FUNERAL PASADENA, MD. 21122 220. BURIAL CREMATION 22b. DATE THEREOF MANE OF CENTERY OR GREMATORY 22d LOCATION (City\_toyh or county) REMOVAL (Specify) B. FUNERAL DIRECTOR'S SIGNATURE DORESS 24b AEEGISTRAR'S SIGNATURE VS A15 (4) 1SM 9/SS

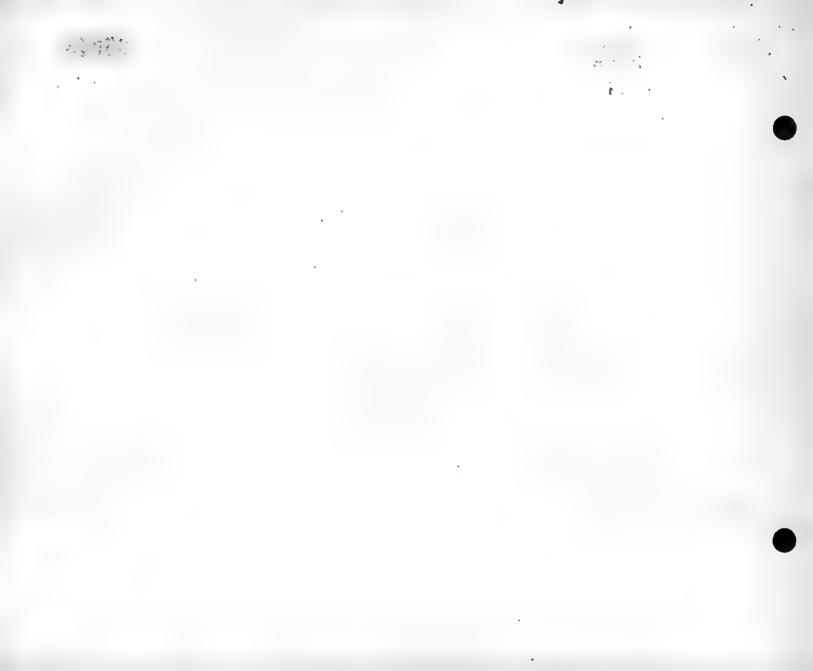


MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. CDUNTY b. COUNTY A A CO Anna Arundel a. STATE MA MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 24 hours Riviera Beach d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE DN A FARM? 8445 Bay Rd 8445 Bay Rd YES ND X 3. NAME OF First Middle DATE Month Year DECEASED Myrtle 0 Herberson Mar 19 67 23 (Type or print) DEATH executed 5. SEX 6. CDLOR OR RACE 8. DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HR\$ 7. MARRIED NEVER MARRIED last birthday) | Months | Days Femal e Oct 25,1892 WIDDWED [ 10a. USUAL DCCUPATION (Give kind of work done | 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN DF WHAT during most of working life, even if retired) Va death certificate 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Lowis Ellis Georgianna 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. I 17. INFORMANT Address 5 (Yes, pa, or unkown) (If yes give war or dates of service) Family Same 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY-IMMEDIATE CAUSE (a) 1947 burial-t burial, 260X DUE TO Anterio- selecte Conditions, If any, which gave rise to Immediate DUE TO cause (a), stating the underlying cause last. CERTIFICATION PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTDPSY PERFORMED? or u YES IT NO T 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part 1 or Part 11 of Item 18.) DR CONTRIBUTING CAUSE DF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED | 20e. PLACE DF INJURY (Home, farm, 2Dc. TIME DF INJURY Month, Day, Year 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. Not While at work 1962 to 3/2 3/67 19 that (I) (we) last 21. I certify that (I) (this hospital) attended the deceased from 12/6 19 (7), and that death occurred at 23 PM, from the causes and on the date stated above. saw the deceased alive on 3/2322a. SIGNATURE 22b. DATE SIGNED to hand STAFF 3-24-67 M.D. DIRECTOR PHYS. 22c. PHYSICIAN'S 22d. director, p ADDRESS NAME (Type) BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) Cedar Hill Burial AA Co 25a. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE Patapsco Ave VR A15 (4) 20M 1/65

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) o COUNTY o STATE b COUNTY 0 ō after death MARY, AND b CITY OR TOWN (If autside carparate mits. C LENGTH OF STAY IN 15 c CTY DR TOWN (If autside corporate limits, write RURAL and give nearest town) ond d NAME OF HOSPITA, OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS form hours DN A FARM? Give Pages YES [ NO Office along with 3 NAME OF Middle Last 4 DATE Month Day Year DECEASED DF (Type or print) DEATH 23 19 6 COLOR OR RACE S SEX DATE OF BIRTH 9 AGE ( n years IF UNDER F UNDER 24 HRS NEVER MARRIED last pirthday) Manihs Days Haurs 43 WIDOWED DIVDRCED l ∎nd2 event 10a USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR BIRTHPLACE Istate or foreign country 12 CITIZEN OF WHAT during most of warking life, even if retired) INDUSTRY COUNTRY 3 powes in day 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME NOWN 16 SOC AL SECURITY NO 17 INFORMANT Address (Yes na, ar unknown) (fiyes a ve war ar dates of service) removal 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH PART ! DEATH WAS CAUSED BY 5 IMMEDIATE CAUSE (6) cremotion, DUE TO Conditions, if any, which gove nse ta immediate cause (a), DUE TO stating the underlying couse last. PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19 WAS AUTOPSY PERFORMED? NO K YES [ 20a EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port 1 of Herp 18) ogent, prior PRIMARY DO CONTRIBUTING CAUSE OF DEATH 20e PLACE DF INJURY (Hame, farm, 20c TIME OF CHILDRY, Marth, Day, Year 20d INJURY OCCURRED (City or fown) (County) (State) factory, street, office bldg, etc.) Nat While may be retained for your FUHIFAL DIFFICTOR: Page AACO MO of work at wark 21 I certify that I taak charge of the remains described above, held an Autopsy Inquiry -Inspection and in my apinion funeral director. death resulted from: Matural causes Accident Suicide ... Homicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL Luterst 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE 5 DEPUTY MEDICAL EXAMINER **EXAMINER'S Meolth** NAME (Type) Address (Street, city, town, or county) BURIAL CREMATION NAME OF CEMETERY OR CREMATORY 235 DATE THEREOF 23d LOCATION (City or Town) S (2) REMOVA (Specify) FUNERAL DIRECTOR REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE VR A15ME (5) MAR 28 Milane 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03057 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT. 2. USUAL RESIDENCE (Where deceased lived if institution Residence before being strong I PLACE OF DEATH o. COUNTY o. STATE b. COUNTY deoth. MARYLAND b CTY OR TOWN (If outside carparate in ts. c LENGTH OF STAY IN th c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town after LEN BURNIE Year Burnie Departi d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) IS RESIDENCE ON A FARM? hours D.O.A-North ARUNDEL - Nas D. WASHINGTON.AV YES NO Item 18. Give Poges Office olong with for 3. NAME OF Middle First 4. DATE Lost Doy DECEASED BERNARD 3 S 19 67 (Type or pnnt) INDE Q DEATH #18 # T S SEX 6 COLOR OR RACE 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 7 MARRIED NEVER MARRIED lost birthdov) Dovs 2/13 DOWED DIVORCED hours event 10o USUAL OCCUPAT ON (Give kind of work done 11 BIRTHPLACE (State or foreign country) 10b K ND OF BUSINESS OR 12 CITIZEN OF WHAT during most of working life, even if retired). INDUSTRY COUNTRY? ony d "pending" in pencil in Chief Medicol Exominer's be executed within 13. FATHER'S NAME .⊆ gud 1S. WAS DECEASED EVER IN U.S. ARMED FORCES 17 INFORMANT or removol, (Yes, no, or unknown). (If yes give wor or dates of service 18 CAUSE OF DEATH (Enter only one cause per line for (o) (b), and (c).)
PART! DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH ardio-yasevler - disease IMMEDIATE CAUSE (o) certificate shauld cremotion, DUE TO Conditions, if any, which gove rise to immediate cause (a). DUE TO stoting the underlying couse bur.ol, c lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED? NO S p 200 EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of Item 18) prior PRIMARY Or CONTRIBUTING CAUSE OF DEATH 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) 20c, TIME OF INJURY Month, Dov. Year (County) (Stote) Hour o.m. foctory, street, affice bldg., etc.) Not While ot work 21. I certify that I taak charge of the remains described above, held on Autopsy Inspection , Inquiry 🔀 and in my opinion **DIRECTOR:** death resulted from, Natural causes 74. Accident 🗍 Homicide . Suicide . Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE ( FUNERAL I the funerol O DEPUTY DEPUTY MEDICAL EXAMINER Health or **EXAMINER'S** 3-8-67 Address (Street, city, town, or county) NAME (Type) 230. BUR AL, CREMATION 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) 0 REMOVAL (Specify) HALL'S CHURCH 24. FUNERAL DIRECTOR 250. REC'D BY REGISTRAR 23 W. MONTGOMERS VR A15ME (5)



| , | (1)  |     | 1             | DIVISION OF  | MARYLAND STATE DEPA<br>VITAL RECORDS, 301 W. PRESTO             |   | RYLAND 21201   |
|---|--|-----|---------------|--|---|---|--|
|   | (M)  |     |               | 03058  |   | OF DEATH                                | 03049  |
| X | PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death the haspital or attending physician. It is certificate has been signed by the attending physician and campletely filled in by the funeral etached far use as the burial-transit permit. Then please reprave carban papers Pages I and Dept. of Health prior to burial, crematian, or removal, and in physician, within 72 hours after death |     |               | PLACE OF DEATH O. COUNTY A. A. CO.   | MARYLAND  | 2. USUAL RESIDENCE (Where dece          | eosed lived, if institution: Residence before admission) b (OUNTY  |
|   | in 24 hours after<br>filled in by the fi<br>papers Pages<br>thm 72 haurs afte  |     |               | b CITY OR TOWN (If outside corporate limits, write RuRAL and give nearest down)                          | C LENGTH OF STAY IN 16  | ENDEUN'S                                | prote limits, write RURAL and give nearest town)   |
|   | hin 24 h<br>filled in<br>papers<br>ithin 72 h  | 4.3 |               | d. NAME OF HOSPITAL OR INSTITUTION (If not in  | n hospital, give street oddress)                                | d. STREET ADDRESS                       | e is residence<br>On a farm?<br>Yes \( \sum \) no \( \sum \)   |
|   | ed within carban figure, with  |     | L             | NAME OF DECEASED [Type or print]  Ruf H  | Middle  | HUSE DEAT                               | H 3 28 1967  |
|   | execution of camp epidone  |     | 5             | EW   | MARRIED NEVER MARRIED DIVORCED DIVORCED                         | 9-13-1898                               | 9 AGE (th years   FUNDER   YEAR   IF UNDER 24 HRS   Months   Days   Hours   Main   Mai |
|   | ertificate be executed with<br>physician and campletely<br>en please reprave carban<br>oval, and in any event, wi  |     | dur           | USUAL OCCUPATION (Give kind of work done<br>ing most of working life, even if retired)                   | 106. KIND OF BUSINESS OR<br>HOUSEWITE                           | 11. BIRTHPLACE (County & Stote, or      | foreign country)  12. CITIZEN OF WHAT COUNTRY?   |
|   | ng phys<br>Then p  |     | 15            | WAS DECEASED EVER IN U.S. ARMED FORCES?  | Ti6. SOCIAL SECURITY NO. 17/1                                   | 14. MOTHER'S MAIDEN NAME                | FIEFIELD   |
|   | at the death cer   |     |               | s, no, or unknown) (If yes give wor or dotes of se   | rvice)  | 149 HAN H.                              | HUSE #2  |
|   | equires that the death certifice physicion. signed by the attending physiburial-transit permit. Then plantial, crematian, or removal,  |     |               | 18 CAUSE OF DEATH (Enter only one couse p<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a).         | Cerubral Hy   | us rhige (                              | Masseye INTERVAL BETWEEN ONSET AND DEATH   |
|   | O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the Page 4 may be retained by the haspital ar attending physician. O FUNERAL DIRECTOR: After this certificate has been signed by the director, pag≡ 3 shauld be detached for use as the burial-transit shauld be filed with the State Dept. af Health priar to burial, cremat   |     |               | Conditions, if ony, which gove (b) (b) rise to immediate cause (o), DUE TO                               | artiruselis   | the Hiest                               | Disease unknown  |
|   | tending<br>tending<br>is been<br>as the<br>priar to  |     |               | stating the underlying couse (c)  PART IF OTHER SIGNIFICANT CONDITIONS CONT                              | DIRHUMO TO DEATH RUT NOT COLATED TO T                           | 1 ypestens                              | LION WAS NITTED  |
|   | AN: The all ar att icate har lear use Health p   | 2   | CERTIFICATION | 200 ACCIDENT WAS UNDERLYING  |   |   | PERFORMED?  YES NO   |
|   | bing PHYSICIAN: The law re<br>by the haspital ar attending<br>liter this certificate has been<br>be detached far use as the<br>State Dept. af Health prior to  |     | CAL CERTI     | OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  20c TIME OF INJURY Month, Day, Year | 20b DESCRIBE HOW INJURY OCCURRED ( 20d *NJURY OCCURRED 20e PLAC | F OF INJURY (Hame, form   20#           | ,  |
|   | by the fitter this be deta   |     | MED           | Hour o.m. 19   | While Not While focts   | ory, street, office bldg., etc.)        |  |
|   | OR ATTENDING be retained by the NRECTOR: After the all should be do advirt the State   |     |               | 21 I certify that (I) (this hospings sow the deceosed alive on 220. SIGNATURE                            |   | 2- 28 , 19 67<br>death occurred at 8 31 | to, 19, that (I) (we) lost M, from couses and on the date stated above.  |
|   | TO HOSPITAL OR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the haspital ar attending TO FUNERAL DIRECTOR: After this certificate has been director, pag≡ 3 shauld be detached for use as the shauld be filed with the State Dept. of Health prior to   |     |               | 22. PHYSICIAN S  | fhous MD  | 22d ADDRESS                             | STAFF - 3-18-1967  |
|   | TO HOSPITAL OR Page 4 may be 1 O FUNERAL DIRE director, page 3 should be filed by  | /   | 230           | NAME (Type) WILLIAM D  BURIAL, CREMATION, 23b. DATE THEREO   | STEPHENUS  1 230 NAME OF CEMETERY OR O                          | 38 CORNHILL                             | T. ANAIRPOLIS MD (County) (State)  |
|   | ·  |     | 13            | REMOVAL (SPECIFY) 3-3/-  | 67 St. HWW.   | E'S /                                   | NNApolis MD.   |
|   | VR A15 (4)<br>25M 1/67   |     | 0             | Kn M Hay Tot, Jans   | (Unopolis, Md   | DATAPR 3                                | 1967 Juanes Juage  |

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03059 CERTIFICATE OF DEATH 24 naurs after death and PLACE OF DEATH and campletely filled in by the funeral nergove carban papers. Pages 1 and 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. COUNTY o. COUNTY papers. Pages 1 hin 72 havrs after MARYLAND c. LENGTH OF STAY IN 1b TOWN (If outside corporate amits, write RURA), and give nearest town POLIS e IS RESIDENCE ON A FARM? (if not in hospital, give street address) d STREET ADDRESS NO V YES requires that the death certificate be executed within NAME OF Middle Lost Month Dov Year DECEASED MARCH ACKSON (Type or print) remove cori DEATH S SFX 9 AGE (In years IF UNDER 1 YEAR IF JNDER 24 HRS. DATE OF BIRTH NEVER MARRIED Instroythdoy) Months Doys Hours any DIVORCED 10g USUAL OCCUPATION (Give kind of work done 12. CITIZEN OF WHAT 10b. & State, or foreign country) and in physician c INDUSTRY during most of working life, even if retired) APOLIS HOME 13. FATHER S NAME remayal, CHRISTIAN LINDEN BORN ARRELL WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT Address 16 SOCIAL SECURITY NO (Yes, no or unknown) (If yes give war or dates of service) ь 213-22-0831 MARTIN T. NACKSON burial, crematian, INTERVAL BETWEEN ONSET AND DEATH CAUSE OF DEATH (Enter only one couse per line for (a) (b) and (c)) signed by the burial-transit PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) MONDUN DUE TO Conditions, if ony, which gove rise to immediate cause (o), DUE TO stoting the underlying couse as the Page 4 may be retained by the haspital ar attending O FUNERAL DIRECTOR: After this certificate has been last. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) far use with the State Dept. of Health NO 🔼 FICAT YES 200 ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURA OCCURRED. (Enter nature of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m Not While factory, street, office bidg., etc.) 19 at work 1960 21. I certify that (1) (this hospital) attended the deceased fram. 19.67, that (1) (wee) last and that death accurred of M, fram causes and an the date stated above saw the deceased alive an 220 SLONATURE ~W DIRECTOR PHYS PHYS director, page shauld be filed 22d ADDRESS 22c. PHYSICIAN" NAME (Type) 230. BURIAL, CREMATION 23b. DATE THEREOF CEMETERY OR CREMATORY 23d. CATION (City or Town) (Stote) (County) SIGNATURE VR A15 (4) 20 M 1/66

De Care and the state of t the second of th

| \$ | 1  | MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |
|----|--|---|
| N. | 0-   | 03060 CERTIFICATE OF DEATH 03051  |
|    | 24 hours after death. filled in by the funeral apers. Pages 1 and 2 n 72 hours after eath.   | 1. PLACE OF DEATH  a. CDUNTY  b. COUNTY  b. COUNTY  |
|    | after of the fu  | Maryland Maryland Anne Arunde   |
|    | Page   | b CITY DR TDWN (if outside corporate limits, write RURAL and give nearest town Annapolis  |
|    | t hou led in sers. 72 ho   | d. NAME OF HOSPITAL DR ASTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE   |
|    |  | h) C) A (U) LENOUEL ABOUTE OU Camedral Street YES NO D  |
|    | executed within 24 hours at and completely filled in by the remove carbon papers. Page an any event, within 72 hours a   | 3. NAME OF First Middle Last 4. DAYE Month Day Year DECEASED (Type or print) Edward JENKINS DEATH 1967  |
|    | com;   | 5. SEX   6. CDLDR DR RACE   7. MARRIED   NEVER MARRIED   8. DATE DF BIRTH   9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HE   |
|    | and and rem  | Male Negro WIDDWED DIVORCED 1078-1403 Yrs.  |
|    |  | 10e. USUAL OCCUPATION (GIVE kind of work done 10b. KIND DF BUSINESS DR INDUSTRY 11b. BIRTHPLACE (Codity & State, or foreign country) 12. CITIZEN DF WHAT COUNTRY?   |
|    | certificate be   | 13. PATHERYS NAME   |
|    | THE SECOND   | 15. WAS DECEASED EVER IN U.S. ARMED PORCES?   16. SOCIAL SECURITY NO.   17. INFORMANT Address   |
|    |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no for unknown) (If yes give war or dates of service)  16. SOCIAL SECURITY NO. 17. UNFORMANT  Address  Address  |
|    | the it pe  | 18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY:  DISET AND DEATH  DEATH |
|    | at the ian. Indeptrument of the crement of the crem | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  My vend where!  |
|    | requires that the ding physician. Deen signed by the burial-transit or to burial, cremanor to burial, crem | conditions, if any, which I am Cercia hear deneural   |
|    | equiring property of the prope | gave rise to immediate (cause (a), stating the DUE TD   |
|    | as as as ir.   | underlying cause last. (c)  |
|    |  | PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)   19. WAS AUTOPS   PERFORMED?   YES   NO   |
|    | PHYSICIAN: The la<br>the hospital or att<br>this certificate h<br>detached for use<br>e Dept. of Health p  | PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)  19. WAS AUTOPS PERFORMED? YES NO [ 20a. ACCIDENT WAS UNDERLYING TO CAUSE OF DEATH OF CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |
|    | HYSICI<br>he hos<br>this ce<br>etache<br>Dept.   |   |
|    | _ — — — — — — — — — — — — — — — — — — —  | 20c. TIME OF INJURY Month, Day, Year 20d. INJURY DCCURRED 20e. PLACE OF INJURY (Home, farm, left of factory, street, office bidg., etc.)    Hour a.m.   |
|    | ATTENDING INCLAIMED IN CETAINED BY I STORY After Should be continued in the State  | 21. I certify that (I) (this hospital) attended the deceased from 120/61, 19 to 5/1/61, 19 that (I) (we) la   |
|    | ATTENDI<br>e retained<br>RECTOR: A<br>3 should<br>with the S   | saw the deceased alive on 2/28/1/19, and that death occurred at 5 20 M, from the causes and on the date stated above 22a, SIGNATURE   |
|    | DIRE<br>DIRE<br>Sige 3   | M.D. ATTENDING MED. STAFF DIRECTOR PHYS. 3/3/67.  |
|    | TO HOSPITAL OR Page 4 may be TO FUNERAL DIRE director, page 3 should be filed v  | 22c. PHYSICIANS NAME (Type) Gentan Citen (1) [22d. ADDRESS Calledral St. Human clis 1.  |
|    | HOS<br>Page<br>FUN<br>FUN<br>direct  | 23a. BURIAL, CREMATION, 23b. DAVE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LDCATION (City, town or county) (State)   |
|    | E E (  | 24 FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR'S SIGNATURE   |
|    | VR AI5 (4)   | The Der H Cuch ale mild DATE MAR 6 1987 followles Judge   |
|    | 20M 1/65   |   |



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03061 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STAIN 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission a. COUNTY o STATE **b.** COUNTY deray is and 3 to Poge Marvland and 2 with the State Department of Anne Arundel Anne Arundel MARYLAND b CITY OR TOWN (If outside carporate limits, C LENGTH OF STAY IN 16 c CITY OR TOWN (If auts de carparate limits, wrîte RURAL and give nearest tawn) and P.M3. write RURAL and give negrest town)
Glen Burnie Glen Burnie d STREET ADDRESS S RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) Office olong with form North Arundel Hospital NO pencil in Item 18. Give Poges Jones Road YES be executed within 24 hours ofter death NAME OF First Middle Last DATE Month Dov Year OF DEATH DECEASED **JOSEPH** JOHNSON 19 (Type or print) March 19 67 5. SEX B DATE OF BRTH AGE (in years F UNDER 1 YEAR 6. COLOR OR RACE 7 MARRIED NEVER MARRIED last birthday) Manths Days Haurs deoth. Male Negro WIDOWED DIVORCED 10a USUAL OCCUPATION (Give kind of work dane 106 KIND OF BUS NESS OR 1). BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? forwarded to the Chief Medical Examiners 13. FATHER S NAME 14. MOTHER'S MAIDEN NAME within 72 Tours 17. INFORMANT Address 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give war or dotes of service) 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN PART I DEATH WAS CAUSED BY: ONSET AND DEATH buriol-transit in IIIny event Multiple Extreme Injuries. IMMEDIATE CAUSE (o) execute the certificate, writing the word This certificate should DUE TO Canditians, if any, which gave (b) nse ta immediate cause (a), DUE TO stoting the underlying couse 0.5 use PART II OTHER S GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY removol, PERFORMED? CERTIFICATION YES [X] NO 20d EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B) 3 should should PRIMARY TO ONTR BUT NG ō Pedestrian struck by auto CAUSE OF DEATH cremation, MEDICAL 20c T ME OF INJURY Manth, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame farm, (City or tawn) (Caunty) (State) factors street, affice bldg , etc.) YOUF Page While Not While at wark Md. A. A. 3/19 1967 at work 21. I certify that I taak charge of the remains described above, held an Autopsy 🔀 and in my apinian Inspection Inquiry FUNERAL DIRECTOR: prior to burrol, Suicide Homicide death resulted fram: Natural causes Accident X Undetermined monner funeral director be retoined CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER X SIGNATURE 3/20/67 DEPUTY MEDICAL EXAMINER **EXAMINER'S** Health Address (Street, city, town, or county) NAME (Type) Charles S. Pettv 23g BURIA CREMATION 23d DCATION (City or Town) DATE THEREON (County) 0 PEMOVAL POPE 25b REGISTRAR'S SIGNATUR 254. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15ME 6M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03062 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death. I. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived if institution Res dence befare admission) o. COUNTY RESERVED AND A STATE OF THE PROPERTY o. STATE **b** COUNTY Anne Arunde MARYLAND fon popers. Pages r within 72 hours after b CITY OR TOWN (If autside carparate iimits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 16 c CITY OR TOWN (If gutside corporate limits, write RURAL and give negrest town) 2 days Glen Burnie Glen Burnie. d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Munch 1819 Lansing Rd. YES 🔲 NOX NAME OF Middle 4. DATE First Last Month Doy Year DECEASED 1967 March 16 (Type or print) Johnson DEATH car Oscar event S SEX B. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS 6 COLOR OR RACE 7 MARRIED NEVER MARRIED X 9. AGE ( n years remove 3-29-05 last birthday) Months Days Hours W M and in ony WIDOWED DIVORCED 10a USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT physician a during most of working life, even if retired) Retired Uni Led Indana States Welder Allis-Chalmers 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME cremation, or removal, signed by the attending ple burial-transit permit. There burial, cremation, or remov John Johnson Anna Flick IS. WAS DECEASED EVER IN U.S. ARMED FORCES? same as 16 SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give war or dates of service) 304-14-2459 Mr. Ivar H. Johnson (Brother) 1943-45 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) INTERVAL BETWEEN PART I DEATH WAS CAUSED BY ONSET AND DEATH tein clevitic IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise ta immediate cause (a), DUE TO by the hospital or attending stating the underlying cause Talux lateral Sclevin be detoched far use os the State Dept. of Health prior to has been last. 19 WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO M mumile YES 🗌 O FUNERAL DIRECTOR: After this certificate 20g ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Port II of item 18.) OR CONTRIBUTING LICAUSE OF BEATH (IF EITHER, NOTHE MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Manth, Day, Year 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, 20f. (City or town) (County) (State) Maur a.m factory, street affice bldg.etc.) Nat While at work at wark certify that (1) (this naspital) attended the deceased fram March (6, 196), to Mach 16, 196), that (1) (we) last be retoined director, page 3 should should be filed with the March 16 19 67, and that death accurred at 5: P M, fram causes and an the date stated above. he deceased alive on. 22b. DATE SIGNED ATTENDING M.D DIRECTOR PHYS 22d ADDRESS 3727 ANN APOLIS Balto 27 RHYSICIAN'S 12 D Poge 4 moy NAME (Type) 672 NORTHBOURNE Baltu/2 RD 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23a. BURIAL, CREMATION. 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) March 20/67 Carmel Cemeterv La Porte. Ind**am**a 24 FUNERAL DIRECTOR **ADDRESS** 25h REGISTRAR STAGNA (FRE VR A15 (4) 20 ■ 1/66 Home / Glen Burnie. Funeral

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03063 CERTIFICATE OF DEATH dinoth. requires that the death certificate be executed within 24 hours after death funeral puo PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if sustitution. Residence before admission) o. COUNTY b. COUNTY Anne Arundel Maryland Anne Arundel ompletely filled in by the fun ve carbon papers Pages I event, within 72 hours after MARYLAND b CITY OR TOWN (If autside corporate limits, write RURAL and give nearest tawn) c. LENGTH OF STAY IN 1b c CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) Severna Park Annapolis d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e IS RESIDENCE ON A FARM? d. STREET ADDRESS filled Anne Arundel General Hospital 219 Holland Rd. NO 3. NAME OF 4. DATE IC. Month Doy Year remove corbon DECEASED 19 67 David JOHNSTON 20 Humphrey March (Type or print) DEATH IF JNDER LYFAR THE UNDER 24 HRS S. SEX 6. COLOR OR RACE 7 MARRIED DC B. DATE OF BIRTH 9 AGE (In years NEVER MARRIED last buthday) Months Days Hours duy ( Male White July 5, 1921 WIDOWED DIVORCED ond 11 BIRTHPLACE (County & State or foreign country) 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT or nit permit. Then please in mail permit. Then please in mailion, or removal, markin during most of working life, even if retired) COUNTRY? S. Maryland welline 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMANT (Yes, no, or unknown) (If yes give wor or dates of service cremation, PART 1. DEATH WAS CAUSED BY. signed by the burial-transit p burial, cremati ONSET AND DEATH IMMEDIATE CAUSE (o) the hospital or attending physician. DUE TO Conditions, if only, which gove rise to immediate couse (a). DUE TO stating the underlying couse State Dept. of Health prior to lost. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) YES X NO 20g. ACCIDENT WAS UNDERLYING [ 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 11 of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e, PLACE OF INJURY (Home, form, (State) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED (City or town) (County) TO FUNERAL DIRECTOR: After this NED I Hour to.m. foctory, street, office bldg., etc \ While Not While at work at work L Page 4 may be retained by 196) to March 20, 19 67 that (1) bead last 21 | certify that (!) (thechasolade attended the deceased from and that death accurred at M, from causes and an the date stated above saw the deceased alive an\_\_\_\_\_ 220 SIGNATURE 22b DATE SIGNED director, page 3 should be filed v PHYS PHYS 22c. PHYSICIANS ADDRESS NAME (Type) SEN NAME OF CEMETERY OR CREMATORY 230. 23c NOVAL (Specify) TRUNERAL DIRECTOR VR A15 (4) 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03064 MEDICAL EXAMINER'S CERTIFICATE OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where deceosed lived if institution Residence a COUNTY o STATE Maryland b COUNTY ... Anne Arundel MARYLAND b. (ITY OR TOWN (If outside corporate mits, write RURAL and give nearest town)
Annapolis ate Department c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C LENGTH OF STAY IN 16 Huntington d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS S RESIDENCE ON A FARM? Anne Arundel General 24 haurs after death 1 in Item 18 Give Pages YES NO alang with 3 NAME OF Middle 4 DATE Month Year DECEASED (Type or print) Waymond JONES DEATH 6 COLOR OR RACE 1 MARRIED X DATE OF BIRTH AGE (In years IF UNDER 1 YEAR FUNDER 24 HRS NEVER MARRIED 3 st birthdoy) Months Haurs WIDOWED D VORCED Male. July 8-Office event within 72 hours after death Colored 100 USUAL OCCUPATION (Give kind of work done 10b K ND OF BUSINESS OR 11 BIRTHPLACE (State or foreign country) 2 CIT ZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Maryland Examiner's This certificate should be executed within "pending" in pencil 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Reland Dorothy Skinner Jones 15 WAS DECEASED EVER NUS ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT (Yes, ng, or unknown) (If yes give wor or dates of service 216-30-4512 Charlotte Jones. Huntingtown, Md. 1B CAUSE OF DEATH (Enter only one couse per ne for (a), (b), and (c)) INTERVAL BETWEEN bur, al-fransit PART I DEATH WAS CAUSED BY ONSET AND DEATH Hemothorax IMMEDIATE CAUSE (o) please execute the certificate, writing the ward I directar. Page 4 snauld be farwarded to the Ch DUE TO In any Conditions, if only, which gove a Laceration of aorta nse to immediate cause (a), DUE TO stating the underlying couse Ō. and and Blunt injury of chest (c) crematian, or remayal, PART II OTHER'S GNIFICANT COND TIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPS: PERFORMED? YES X NO [ 200 EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18) 3 shauld EXAMINER: CAUSE OF DEATH Passenger in auto which ran off road while making curve files 20d NJURY OCCURRED ; 7:00 Hour Sex 3 31 20e PLACE OF INJURY (Home, form 20f (City or town) foctory, street, office bldg, etc.) While Not While DIRECTOR: Page 19 67 Md. of work at wark A.A. 21. I certify that I took charge of the remains described above, he'd an Autapsy Inspection . Inquiry . and in my opinian funeral directar. death resulted fram. Natural causes Accident y Su'cide Hamicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASS STANT MED CA. EXAMINER prior SIGNATURE may be re FUNERAL I DEPUTY MEDICAL EXAMINER **EXAMINER'S** 4-2-67 RUSSELL S. FISHER, M.D. NAME (Type) Address (Street, city, town, or county) 23c NAME OF CEMETERY OR CREMATORY 230 B&R AL, CREMATION, 23b DATE THEREOF 23d LOCATION (City or Town) (Stote) REMOVAL (Specify) 4-6-67 Patuxent Ch.Cem. Huntingtown Ca Md. 2So REC'D BY REGISTRAR 24. FUNERAL DIRECTOR 25b. REGISTRAR S SIGNATURE VR A15ME (5) 6M 1/67



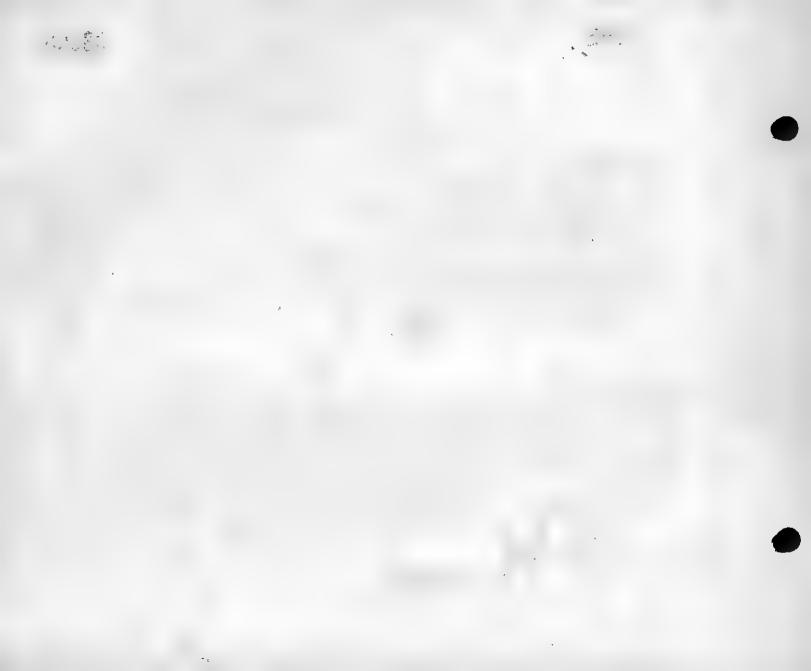




MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W, PRESTON STREET, BALTIMORE, MARYLAND 21201 03065 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) D. COUNTY D. STATE b. COUNTY ANNE ARUNDEL ANNE ARUNDEL **MARYLAND** b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3 Hours GLEN BURNIE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS ON A FARM? KIMBROUGH ARMY HOSPITAL 303 GEORGIA AVENUE NE NAME OF First Middle 4. DATE Lost Month Dov DECEASED (Type or print) ROBERT FRANCIS KING MARCH DEATH S. SEX 6. COLOR OR RACE NEVER MARRIED 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 7 MARRIED 8 DATE OF BIRTH last buthdovi Months 2 FEB 1902 MALE WHITE WIDOWED DIVORCED 1Do JSUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY during most of working life even if retired) INDUSTRY the offending physicion sit permit. Then pleose JACOBS CREEK. PA Serviceman retired U.S.ARMY 13 FATHER'S NAME 14. MOTHER'S MA, DEN NAME or removal, MARGARET MOHR FRED KING WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Address Glen Burnie, Md (Yes, no, or unknown) (If yes give wor or dotes, of service) 218-36-4551 Emma King(wife) 303 Georgia Ave.NE 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c) PART 1 DEATH WAS CAUSED BY INTERVAL BETWEEN signed by the burial-tronsit | burial, cremati ONSEL AND DEATH HEMORRHAGE INTO LEFT CHEST & ABDOMINAL CAVITIES IMMEDIATE CAUSE (o) DUE TO 6 YEARS ANEURYSM OF AORTA Conditions, if only, which gave ) use to immediate couse (o), DUE TO stating the underlying couse ATHEROSCLEROSIS AND/OR LUES 20 YEARS las\* PART I OTHER IGN FICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) WAS AUTOPSY PERFORMED? YES X NO 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18) 200 ACCIDENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 2Dc. TIME OF INJURY Month, Doy, Year 2Dd INJURY OCCURRED 20e, PLACE OF NJURY (Home, form, ((thy or fown) (County) (Stote) Hour o.m. Not While of work foctory, street, office bldg., etc.) of work ATTENDING Poge 4 may be retained by the COR. After 21. I certify that this haspital) attended the deceased from 15 March 1967, to 15 March 1967, that (# (we) lost saw the deceased give on 15 March 19 67, and that death occurred at 4:20 M, from couses and on the date stated above. 22b DATE SIGNED 220 \5 GNATURE ATTENDING STAFF PHYS. 15 March 1967 director, page 3 should be filed v DIRECTOR PRYS 22d ADDRESS BERNARD T. KRAVITZ, CPT, MC KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23b. DATE THEREOF 23d, LOCATION (City or Town) 230 BURIAL CREMATION. (County) (Stote) Burial (Specify) 20 March 67 Glen Haven Memorial 1 Glen Burnie 250. REC'D BY REGISTRAR 250 REGI 24 FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.



| 1 4  |               | MARYLAND STATE DEPARTMENT OF HEALTH  Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |  |  |  |  |  |  |
|--|---------------|--|--|--|--|--|--|--|--|
| FOR STATE  |               | 03066 THE MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03056  |  |  |  |  |  |  |  |
| BLALTH BEPT!   | 1             | PLACE OF DEATH  2. USUAL RESPONDE (Where deceased lived, If Institution: Residence before admission)   |  |  |  |  |  |  |  |
|  |               | MARYLAND MARYLAND  |  |  |  |  |  |  |  |
| funeral<br>funeral<br>may be<br>rtment<br>death.   |               | b. CHY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CHY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |  |  |  |  |  |  |  |
| the fune of the fune fune fune fune fune fune fune fun   | -             | d, MAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street andress) d. STREET ADDRESS e. IS RESIDENCE   |  |  |  |  |  |  |  |
| ate ate  | 3             | Cli Cli Deneral 28 Edgewood Road VES NO NO   |  |  |  |  |  |  |  |
| 2, and PM3. FM3. If the St   | 3             | NAME OF DECEASED First Modele 4 Last 4. DAYE Month Day Year  |  |  |  |  |  |  |  |
| f any<br>1, 2, a<br>1 PM3<br>1 PM3<br>in 72  | -5            | Type or print DEATH  SEX 6. COCOR OR RADE 7. MARRIED 8. DATE OF BIRTH  9. AGE (In years   FUNDER 1 YEAR   FUNDER 244HRS.   |  |  |  |  |  |  |  |
| Pages 1, th form the form within   |               | Male ( of wioowed Divorceo 7-10-1916) Sast Hirthday) Months Days Hours Min.  |  |  |  |  |  |  |  |
| [8 8 8 8]  | 4 d           | ON USUAL OCCUPATION (GIVE kind of workdone 10b. KIND OF BUSINESS OR USUAL OCCUPATION (GIVE kind of workdone 10b. KIND OF BUSINESS OR USUAL OCCUPATION (GIVE kind of workdone 10b. KIND OF BUSINESS OR USUAL OCCUPATION (GIVE kind of workdone 10b. KIND OF BUSINESS OR USUAL OCCUPATION (GIVE kind of workdone 10b. KIND OF BUSINESS OR USUAL OCCUPATION (GIVE kind of workdone 10b. KIND OF BUSINESS OR USUAL OCCUPATION (GIVE kind of workdone 10b. KIND OF BUSINESS OR USUAL OCCUPATION (GIVE kind of workdone 10b. KIND OF BUSINESS OR USUAL OCCUPATION (GIVE kind of workdone 10b. KIND OF BUSINESS OR USUAL OCCUPATION (GIVE kind of workdone 10b. KIND OF BUSINESS OR USUAL OCCUPATION (GIVE kind of workdone 10b. KIND OF BUSINESS OR USUAL OCCUPATION (GIVE kind of workdone 10b. KIND OF BUSINESS OR USUAL OCCUPATION (GIVE kind of workdone 10b. KIND OF BUSINESS OR USUAL OCCUPATION (GIVE kind of workdone 10b. KIND OF BUSINESS OR USUAL OCCUPATION (GIVE kind of workdone 10b. KIND OF BUSINESS OR USUAL OCCUPATION (GIVE kind of workdone 10b. KIND OF BUSINESS OR USUAL OCCUPATION (GIVE kind of workdone 10b. KIND OF BUSINESS OR USUAL OCCUPATION (GIVE kind of workdone 10b. KIND OF BUSINESS OR USUAL OCCUPATION (GIVE kind of workdone 10b. KIND OF BUSINESS OR USUAL OCCUPATION (GIVE kind of workdone 10b. KIND OF BUSINESS OR USUAL OCCUPATION (GIVE kind of workdone 10b. KIND OF BUSINESS OR USUAL OCCUPATION (GIVE kind of workdone 10b. KIND OF BUSINESS OR USUAL OCCUPATION (GIVE kind of workdone 10b. KIND OF BUSINESS OR USUAL OCCUPATION (GIVE kind of workdone 10b. KIND OCCUPATION (GI |  |  |  |  |  |  |  |
| The Section of the Se |               | 3. FATHER'S MAINE 14. AND HER'S MAIDEN NAME  |  |  |  |  |  |  |  |
| 28 97  |               | THEMOMES KINGES COMMONDA MADS  |  |  |  |  |  |  |  |
| n 24 hour in Item in Item is Office to Tile part all, and in   | - 7           | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address Yes, no, or unknown) (11 gres give was prolates of service)  |  |  |  |  |  |  |  |
| within 2<br>pencil in<br>miner's C<br>permit. I<br>removal,  |               | 1 B. CAUSE OF DEATH (Enter only one cause per line for AD, 40), and (c).)  |  |  |  |  |  |  |  |
| ed w<br>in pe<br>xamil<br>xamil<br>it pe   |               | PART I. DEATH (Enter only one cause per line for all b), and (c).]  PART I. DEATH WAS CAUSEO BY:  IMMEDIATE CAUSE (a)  REPORT OF THE PROPERTY  |  |  |  |  |  |  |  |
| Ild be executed 1 "pending" in if Medical Exar Bransit a burial-transit cremation, or its answer in the cremation in the cremation in the property of the cremation in the property of the pro |               | OUE TO   |  |  |  |  |  |  |  |
| be ey<br>pend<br>Medic<br>Medic  |               | Conditions, if any, which   (b)   (b)  |  |  |  |  |  |  |  |
| ould "ief" a bu  |               | cause (a), stating the OUE TO underlying cause last. (c)   |  |  |  |  |  |  |  |
| certificate should be executed within iting the word "pending" in pencil is led to the Chief Medical Examiner's Id be used as a burial-transit permit, prior to burial, cremation, or removal  | , A           |  |  |  |  |  |  |  |  |
| the the tro  | CERTIFICATION | YES ND Z  20a. EXTERNAL CAUSE WAS 20b. OESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part 1 or Part 11 of Item 18.)   |  |  |  |  |  |  |  |
| ritin<br>ritin<br>rded<br>uld b  | Fax           | 20a. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH.  20b. OESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part 1 or Part II of Item 18.)  |  |  |  |  |  |  |  |
| EXAMINER: This certific certificate, writing thould be forwarded to fles.  OR: Page 3 should be usignated agent, prior to  | MEDICAL       |  |  |  |  |  |  |  |  |
| infication in the factor of th |               |  |  |  |  |  |  |  |  |
| L EXAMINER:<br>he certificate<br>should be fo<br>files.<br>TOR: Page 3<br>lesignated ag  | V             | 21. I certify that book charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from:  |  |  |  |  |  |  |  |
| the the ur fill of the ship of |               | CHIEF MEDICAL EXAMINER   |  |  |  |  |  |  |  |
|  |               |  |  |  |  |  |  |  |  |
| WEDI<br>Secute<br>or you<br>DIR  |               | ACTUAL SIGNATURE M.D. ASSISTANT MEDICAL EXAMINER 22. DATE SIGNED   |  |  |  |  |  |  |  |
| UTY MEDICA<br>execute to<br>or. Page 4<br>ed for your<br>ERAL DIREC  |               | EXAMINER'S 6 GEPUTY MEDICAL EXAMINER 3-25-67   |  |  |  |  |  |  |  |
| DEPUTY<br>lease er<br>irector.<br>etained<br>FUNERA<br>f Health  | 2             | EXAMINER'S 6 LATOLA OEPUTY MEDICAL EXAMINER 3-25-67  |  |  |  |  |  |  |  |
| TO DEPUTY MEDI- please execute director. Page retained for yo TO FUNERAL DIR   | 2             | EXAMINER'S NAME (Type)  3-25-67  Address (Street, city, town, or county)  3-25-67  3a. BURIAL, CREMATION, 23b. DATE THEREOF   23c. Name of cemeters or Crestation (21ty, town or county)   (8) ata)  |  |  |  |  |  |  |  |



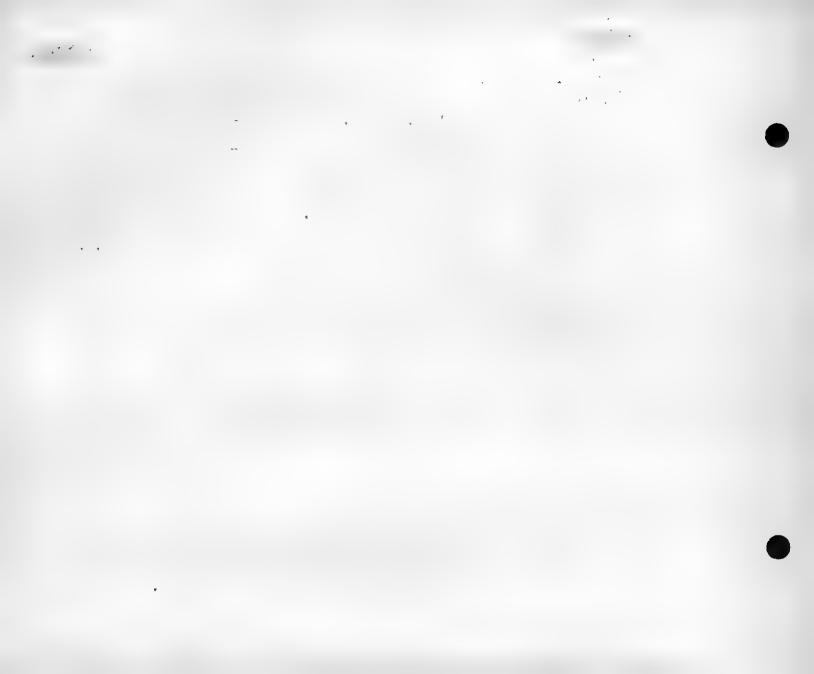
| 1                                       | DIVISION OF  | MARYLAND STATE DEPA<br>VITAL RECORDS, 301 W. PRESTO |   | AND 21201  |
|---|--|---|---|--|
| deoth.                                  | 03067  | CERTIFICATE   | OF DEATH  | 03057  |
| er de                                   | PLACE OF DEATH 1. COUNTY Anne Arundel  | MARYLAND  | o. STATE Maryland   | lived, if institution Residence before admission) b. COUNTY Anne Arunde1         |
|   | o CITY OR TOWN (If autside corporate limits, write RURAL and give nearest fown) Annapolis      | c LENGTH OF STAY IN 16                              | City -  | limits, write RURAL and give nearest town) Annapolis                             |
|   | i NAME OF HOSPITAL OR INSTITUTION (If not in<br>Anne Arundel Ge                                | neral Hospital                                      | d. STREET ADDRESS 294 West Street   | e is residence<br>on a farm?<br>yes \( \) no \( \)                               |
| 3 N<br>C<br>S. S                        | NAME OF First DECEASED Type or print)  Anna  EX 6. COLOR OR RACE 7                             | Middle  Katsereles  MARRIED NEVER MARRIED   8       | LEANOS DEATH DATE OF BIRTH  1 DATE OF BIRTH | Month Day Year  March 20, 1967  GE (In years   IF UNDER 1 YEAR   IF UNDER 24 HRS |
| 10a                                     | male White   | WIDOWED DIVORCED M;                                 | arch 16,1893. 7   | ost birthdoy) Months Days Hours Min  A country) 12 CITIZEN OF WHAT               |
| durir                                   | ng mast at walking life, even if retired)  FATHERS NAME  | INDUSTRY HOME                                       | Greece 14 MOTHER, S MAIDEN NAME   | COUNTRY? 4.5A.   |
| IS.                                     | HRIS KATSERE<br>WAS DECEASED EVER IN U.S. ARMED FORCES?  |   | POLYXENE /  | KARKAN9ES  |
| (163                                    | IB. CAUSE OF DEATH (Enter only one cause<br>PART I. DEATH WAS CAUSED BY:                       |   | IAMES D. L.   | EANOS  INTERVAL BETWEEN ONSET AND DEATH  |
| burial, cremation, or removal, and      | DUE TO   | 191101111   | 13  | 1 stronia  |
| 1 1                                     | Canditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |   | 8351716   | Wears,   |
| NOH                                     | PART H. OTHER SIGNIFICANT CONDITIONS CONT  |   | HE TERMINAL DISEASE CONDITION GIVEN II  | N PART I(o)  19 WAS AUTOPSY PER OR MID? YES NO                                   |
| L CERTHECATION                          | 20a ACC DENT WAS UNDER YING CONTRIBUTING CHARGE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | 201 DESCRIBE HOW INJURY OCCURRED. (1                | Enter nature of injury in Part 1 or Port II   | of item 18)  |
| With the Stole Dept. of Redich prior to | 20c TIME OF INJURY Month, Day, Year Pm. 3 - 14 196   | While Nat While of work at wark                     | ry, street, affice bldg., etc.) Ann   | rapolis AmeArni (Store)  |
|   | 2). I certify that (I) (this haspit saw the deceased alive on 220. SIGNATURE                   | al) attended the deceased fram                      | death accurred at 9:25 Mb.  | ram causes and an the date stated above.  22b DATE SIGNED                        |
| should be filed wit                     | 27c PHYSICIAN'S (1)  | Mallman MD  | ATTENDING MED DIRECTOR DIRECTOR 22d. ADDRESS, 11  | STAFF C  |
| 230                                     | NAME (Type) 1 3 Y U (3   | OF, ~ 123c NAME OF CEMETERY OR C                    | REMATORY 2304 OCAT  | (P2 S) Atriaged: May  (TON (City or Jown) (Start)  (Start)                       |
| 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1   | FEMOVAL (Specify) 3-33   | ST. DEMET   | RIUS HUN<br>25a. RECD BY REGISTRAR  | A POLIS H. H. M. 256 REGISTRAR'S SIGNATURE                                       |
| 广上                                      | Ku M. oty/bot for  | 1 Uniapolis, 19                                     | a. MAR 27 198   | 37 Johnson Judge   |



MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03069 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived if institution: Residence beto o. COUNTY o. STATE b. COUNTY Anne Arundel Maryland Anne Arundel MARYLAND b. CITY OR TOWN (If autside carparate simits, write RURAL and give nearest town) c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) t LENGTH OF STAY IN 16 RURAL - Crownsville Annapolis 11 hr. 10
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10 min. d. STREET ADDRESS IS RES DENCE ON A FARM? Rt-1, Box-201 Anne Arundel General Hospital NAME OF First Middle Last 4 DATE Month Year Day DECEASED Mary LEEDY Rose March 19 67 (Type or print) DEATH S SEX 6. COLOR OR RACE 8 DATE OF BIRTH 9. AGE (in years IF UNDER YEAR IF UNDER 24 HRS 7 MARRIED **NEVER MARRIED** birthday) Months Days Hours X Nov. 8. 1895 ond in ony WIDOWED DIVORCED White Female ond IDO USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT piease during most of workings title, even if retired) COUNTRY? Maryland 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME or removol, 15 WAS DECLASED EVER IN U.S. ARMED FORCES? (Yes, no. of upicytown) (If yes give wor or dotes of service) 17 INFORMANT 16 SOCIAL SECURITY NO Address CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) INTERVAL BETWEE signed by the buriol-transit p PART . DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (a) DUE TO Canditions, if any, which gave (b) rise to immediate cause (o), DUE TO stating the underlying cause the State Dept. of Health prior to last. SD WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBLTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) YES NO certificote 2Do ACCIDENT WAS LINDERLYING [7] 2Db DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port or Part II of item .8) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c TIME OF INJURY Month, Day, Year 2Dd INJURY OCCURRED 2De PLACE OF INJURY (Hame, farm, (City or town) (County) (State) Hour om factory, street office blda. etc.) While Not White OR ATTENDING 21. I certify that (I) (this Reserve) attended the deceased from , 19\_\_\_, that (I) \$3@) last and that death accurred at 1523 M, from causes and an the date stated above O FUNERAL DIRECTOR: saw the deceased alive an 3 22b DATE SIGNED 220 SIGNATUR MED DIRECTOR director, page 3 should be filed v 22d ADDRESS O HOSPITAL PHYSICIAN'S NAME (Type) Severna Park, Md. BOR AL CREMATION DATE THEREOF 230 REMOVAL (Specify) UN RAL DIRECTOR 25g. RECD BY REGISTRAR VR A15 (4) 25M 1/67



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03070 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE I PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, funstitution Residence before admission o. COUNTY o. STATE b. COUNTY Maryland Anne Arundel Anne Arundel MARYLAND Artile State Department CTY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. CITY OR FOWN (If outs de corporate limits, write RJRAL and give nearest town) c. LENGTH OF STAY IN 16 Annapolis Annapolis d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e 15 RESIDENC d. STREET ADDRESS ON A FARMS with form Anne Arundel General Hospital 248 Prince George St in Item 18. Give Poges NAME OF Lost 4 DATE OF DEATH DECEASED / Lewis S. SEX 6. COLOR OR RACE MARRIED NEVER MARRIED 9 AGE (In years lost berthdoy) Months DIVORCED WIDOWED white female 12 CITIZEN OF WHAT 100 USUAL OCCUPATION(G ve kind of work done pending" in pencil in ef Medicol Exominer's 13. FATHER'S NAME 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or prinknown) (If yes give wor or dotes of service) 16 SOCIAL SECURITY NO NTERVAL BETWEEN 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c)) ONSET AND DEATH any event PART DEATH WAS CAUSED BY Arteriosclerotic cardiovascular disease IMMED ATE CAUSE (o) . DUE TO Conditions, if ony, which gove rise to immediate couse (o), forwarded to DUE TO stoting the underlying couse WAS AUTOPS PART II OTHER S GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) removal, PERFORMED? CERTIFICATION Pulmonary emphysema and prulent bronchitis NO 20b DESCRIBE HOW IN, JRY OCCURRED (Enter nature of injury in Port I or Port II of Item 18) 20o EXTERNAL CAUSE WAS PRIMARY Or CONTRIBUTING CAUSE OF DEATH. MEDICAL 20c. T.ME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF NJURY (Home form 20f (City or town) (County) foctory, street, office bldg., etc.) Hour o.m. at work FUNERAL DIRECTOR: P 21. I certify that I took charge of the remains described above, held an Autopsy Inspection ... Inquiry . and in my apintan death resulted from. Natural causes x. Accident Suicide | Hamicide Undetermined manner funeral director be retoined CHIEF MEDICAL EXAMINER 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER prior DEPUTY MEDICAL EXAMINER Werner U. Spitz, 3/5/67 Address (Street, city, town, or county) (County) VR A15ME (5) 6M 1/67

MARYLAND & THE DEPARTMENT OF HEALTH



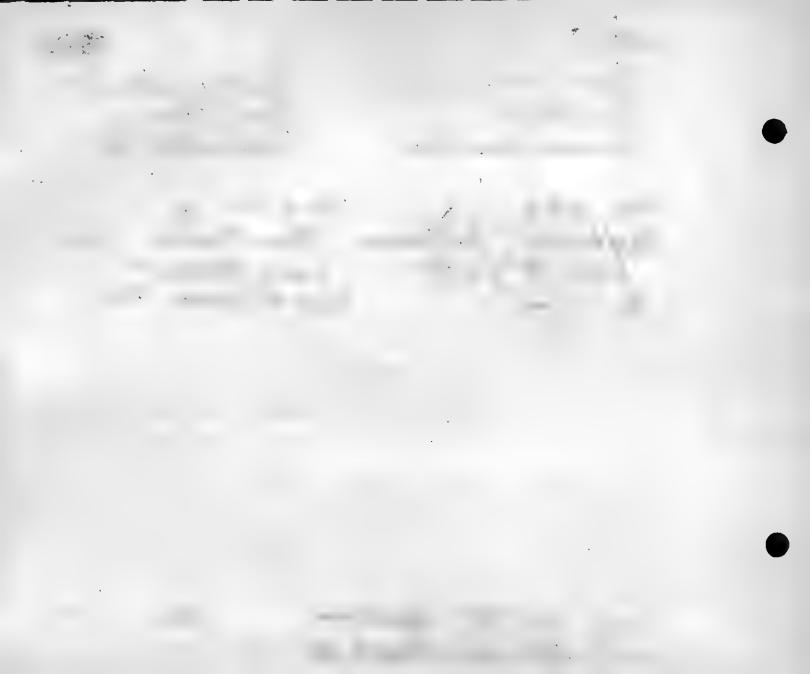
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03071 CERTIFICATE OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission). a. COUNTY b. COUNTY MARYLAND requires that the death certificate be executed within 24 haurs after physician and completely filled in by the b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 (If passide corparate limits, write RURAL and give nearest tawn) RURAL and give negrest town) cen Burne d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ON A FARM NO K NAME OF DATE Year DECEASED ELORIS OF 1967 DEATH (Type or point) AGE (In years 1 YEAR I IF UNDER 24 HRS SEX 6 COLOR OR RACE DATE OF IF UNDER 7 MARRIED NEVER MARRIED last bythday) Months Dovs Haurs any DIVORCED WIDOWED 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT 10a USUAL OCCUPATION (Give kind of work done inty & State, or fareign country). and in COUNTRY? INDUSTRY during most of working ite, even if retired Houseur 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17 INFORMANT (Yes, no or unknown) [(If yes give war or dates of service 18. CAUSE OF DEATH (Enter only one couse per line-for (a), (b), and (t).) INTERVAL BETWEEN burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: signed by IMMEDIATE CAUSE (o) physician. burial. Canditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying couse 10 FUNERAL DIRECTOR: After this certificate has been as the priar ta WAS ALTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) NO X YES the haspital ar TO 20g ACCIDENT WAS UNDERLYING [ 205. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 1B.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, form, (City or town) (County) [Store] 20c. TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) Hour o.m. Nat While at work of work þ 21 | certify that (1) (this hospital) attended the deceased fram // be retained should 19.67, and that death accurred at Ziech M, from causes and an the date stated above saw the deceased alive an 220 SIGNATURE 22b. DATE SIGNED PHYS DIRECTOR PHYS. , page be filed ADDRESS 22c. PHYSICIAN S NAMF (Type) directar, should 23g. BURIAL CREMATION 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) REMOVAL (Specify) Baltimore. Md Burial 3/28/67 Loudon Park Cemetery 250. REC D BY REGISTRAR 24. FUNERAL DIRECTOR Howard H. Hubbard Funeral Home 4107 Wilkens Ave Charles VR A15 (4) 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03072 CERTIFICATE OF DEATH ond 2 requires that the death certificate be executed within 24 haurs after death. death. 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission. filled in by the funeral papers. Pages I and PLACE OF DEATH o. COUNTY o. STATE b COUNTY Anne Arundel Maryland Anne Arundel MARYLAND b CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 c CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) RURAL - Edgewater davs Annapolis d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS IS RESIDENCE within 72 ON A FARM? Anne Arundel General Hospital Rt-3. Box-780 3. NAME OF Middle 4 DATE Month Year pou Day and completely DECEASED 19 67 MARTIN 2 Ella Althea March (Type or pnnt) DEATH ond in any event, S. SEX 6 COLOR OR RACE R DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIED remove ost burthday) Months Hours White Female WIDOWED X DIVORCED IDg USUAL OCCUPATION (Give kind of work done 10h KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? INDUSTRY PRINCE WM Virginia 13. FATHER S NAME 14. MOTHER'S MAIDEN NAME buriol, cremotion, or removol, Stellens IS WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT (Yes, no, ar unknown) (If yes give war or dates of service) JOHN R. MARTINI. ORINA. 18. CAUSE OF DEATH (Enter only one cause per lipe-fox (a), (b) INTERVAL BETWEEN signed by the burial-transit T AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o' DUE TO Conditions, if any, which gave rise to immediate cause (a). DUE TO stating the underlying couse prior to has been last. 19 WAS AUTOPSY PERFORMED? PART 1: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) be detoched for use State Dept. of Health NO O FUNERAL DIRECTOR: After this certificate 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20g ACCIDENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e PLACE OF INJURY (Home, form, 20d INJURY OCCURRED (City or lawn) (County) (State) 20c. TIME OF INJURY Month, Day, Year factory, street, affice bldg., etc.) Haur a.m. Nat While at wark at work 21. I certify that (1) (this kessited) attended the deceased fram. , 1965 Tto March 2., 19.67, that (1) (west last be retoined saw the deceased alive an March 2. 19 67, and that death accurred at M, from causes and an the date stated above 22a. SIGNATURE 22b. DATE SIGNED STAFF PHYS. ATTENDING director, poge 3 should be filed v DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S Page 4 moy NAME (Type) Richard I. Hochman. M.D. Franklin St., Annapolis, Md. 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town (State) 23g. BURIAL CREMATION REMOVAL (Specify) RECAY 250. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) 20 M 1/66



| / | 1 18 /   |            | MARYLAND STATE DEPARTMENT OF HEALTH  Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, M.  | ADVI AND                                   |
|---|--|------------|--|--|
| 4 | FOR STATE  | }          | 03073 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  | 03063                                      |
|   | HEALTH DEPT.   | 1.         | PLACE OF DEATH  2. USUAL RESIDENCE (Where deceased lived, 1s, Decitation: a, COSTANT)  b, SOUNTY b, SOUNTY   | Residence before admission)                |
|   | 470 ±4   |            | Hine HIVINGET MARYLAND TATY/and Thine  | 4rundel                                    |
|   | essary,<br>funeral<br>may be<br>artment  |            | Write RURAL and gladingerst town)  | L'and give nearest town)                   |
| 4 | # 5 5 E  |            | d. NAME OF HOSPITAK OR INSPITUTION (If not Inyhospital, give street address) d. STREET SORESS  | 6. IS RESIDENCE<br>ON A FARM?              |
| ì | delay cassary, and 3 to the funeral page 5 may be State Department hours after death.  |            | Shoreham Beach Koad Shoreham Beach Rd.   | YES NO                                     |
|   | after death. If any delay in Give Pages 1, 2, and 3 to ong with form PM3. Page ss 1 and 2 with the State Is any event-within 72 hours a  | 3.         | NAME OF FIRST Middle Last 4. DATE Month DECEASED OF OF DEATH 3   | Day Year                                   |
|   | II. 2.   | 5.         | SEX   G. CDUOR OR, RACE   7. MARRIED   NEVER MARRIED     8. DATE OF BIRTH   9. AGE (in years IF UNDE   | R 1 YEAR IF UNDER 24 HRS.  Days Hours Min. |
|   | ages form  | 1          | Tale White Widowed Divorced July 1) 16 /6 yrs.   |  |
|   | ive Pages 1, 2<br>with form P<br>with form P<br>1 and 2 with<br>event-within   | 10a<br>dui | dige Jost of frogling lift, eyen if retired) O INDUSTRY  | CITIZEN OF WHAT                            |
|   | burs afte<br>n 18. Gi<br>e along<br>pages 1<br>in any c  | 13         | SOUTH BUILDER CIVIL SETVICE 1/4403 //41/18/18  | USH  |
|   | 4 hours tem 18 ffice alt   |            | Louis 19 Carter Laura Merchant   |  |
|   |  | 15<br>(Y   | WAS DRCEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT MCCarter Address 22. poper unknown) (If yes give war or dates of service)  |  |
|   | within 2<br>pencil in<br>miner's C<br>permit.  | -          | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  | INTERVAL BETWEEN                           |
|   | ted v in processing position for re  |            | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)   | DNSET AND DEATH                            |
|   | ing", cal I  |            | HOTT DUE TO CO LET HE COLOR  |  |
|   | d be executed "pending" in Medical Exa burial-transit cremation, or  |            | Conditions, If eny, which gave rise to immediate (b) Collection the DuE TD   |  |
|   | hould bird hief hief al, cl  |            | underlying causa last. (c)   |  |
|   | ficate shot the work the chi of t       | TION       | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(8)   | 19. WAS AUTOPSY<br>PERFORMED?<br>YES NO    |
|   | rtifica<br>ig th<br>to t<br>be us<br>or to   | CERTIFICAT | 20a. EXTERNAL CAUSE WAS   20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1.   |  |
|   | is cel<br>mritir<br>arded<br>ould I  |            | 20a. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1. CAUSE OF DEATH.  | 8-14-14-14-14-14-14-14-14-14-14-14-14-14-  |
|   | FR. This certificate, writing forwarded to 3 should be agent, prior  | MEDICAL    | 20c. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) factory, street, office bldg., etc.)   | ounty) (State)                             |
|   | the certificates the certificates to the certificates the       | E E        | p.m. 19 et work   at work   21.   certify that   took charge of the remains described above, held an Autopsy   , Inspection   , Inquiry  | and in my opinion                          |
|   | esign:   |            | death resulted from; Natural causes , Accident , Suicide , Homicide , Undetermined manner  |  |
|   | D O ~ Z  |            | ACTUAL CHIEF MEDICAL EXAMINER CHIEF CHIEF MEDICAL EXAMINER CHIEF CHIEF CHIEF CHIEF CHIEF CH | 22. DATE SIGNED                            |
|   | MEDICA<br>E Page 4<br>for your<br>NL DIRECTOR IS OF ITS O |            | SIGNATURE M.D. DEPUTY MEDICAL EXAMINER   | -1 /2                                      |
|   | DEPUTY MEDIO: EXU<br>please execute the c<br>director. Page 4 shou<br>retained for your files<br>of Health or its design   |            | NAME (Type) L. L///////// Madress (Street, City, town, or bounty)  | $\frac{3/1/6}{2}$                          |
|   | O DEPUTY MED<br>please execut<br>director. Page<br>retained for yo<br>O FUNEAL DII<br>of Health or ii  | 23         | BENOVAL (Specify) 3-4-1967 Hope Chapel 1230. LOCATION (City, town or c   | bunty) / d tate)                           |
|   |  | 24         | FUNERAL PIRECTOR 258. REC'D BY REGISTRAR 258. REGISTRAR 258. REGISTRAR 258.  | R'S SIGNATURE                              |
|   | VR AI5ME (5) 5<br>5M 1/65  | 4          | oly M. Taylor Lors Amapolis, Mr. DATE MAR 3 1967 guid  | 0 6  |
|   |  | 1/         | V  |  |



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03074 CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH b. COUNTY Anne Arundel o. COUNINT o. SMaryland Anne Arundel MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b b. CITY OR TOWN (If outside corporate limits, fs/1116//Glen Burnielité 16 days Millersville. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENC ON A FARM? North Arundel Hospital Rt. 2 Box 201 YES X NO T 3. NAME DF DECEASED 4. DATE Middle Lost Year Doy W. 1967 Carl McLane (Type or print) DEATH 8 DATE OF BIRTH 9-20-00 IF UNDER 1 YEAR IF UNDER 24 HRS S SEX AGE (In veors 6. COLOR OR RACE 7 MARRIED T NEVER MARRIED los birthdoy) Months Days Hours Male White WIDOWED DIVORCED 100 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) **INDUSTRY** Maryland
14. MOTHER'S MAIDEN NAME Du Pont Co. Retired 13. FATHER S NAME Benjamin McLane Mary E. Longest 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service) 17. INFORMANT 16 SOCIAL SECURITY NO. Catherine McIano, same as INTERVAL BETWEEN 18. CAUSE DF DEATH (Enter only one couse per line for (a), (b), and (c).) ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gove rise to immediate couse (o), DUE TO stoling the underlying cause last WAS AUTOPS PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) CERTIFICATION YES [ NO 205. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING [1] OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL (Stote) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) 20c TIME OF INJURY Month, Doy, Year Hour o.m. factory, street, office bldg., etc.) Not While of work at wark 2]. I certify that (1) (this hospital) attended the deceased fram 7-16-saw the deceased alive an\_ 22b. DATE SIGNED 220. SIGNATURE ATTENDING MED.
DIRECTOR STAFF M.D. PHYS 22d ADDRESS 22c. PHYSICIAN'S NAME (Type) 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 230. BURIAL, CREMATION 23b DATE THEREOF (County) (Stote) REMOVAL (Specify) Glen Haven Memorial Glen Burnie Burial Annil 67 25o. REC'D BY REGISTRAR 24 FUNERAL DIRECTOR

Kirkley Funeral Home. Glen Burnie. Md.

Whenter

196

hours

paper

physician on please

attending property of the

and

remaval,

b

cremation,

prior to b

**burial-transit** 

signed

this certificate

detached

director, page 3 should be filed a

TO HOSPITAL Page 4 may TO FUNERAL I

OR ATTENBING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs

the hospital ar attending physician.



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03076 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) PLACE OF DEATH and completely filled in by the funeral remove carbon popers. Pages 1 and in ony everthympth)n 72 hours after ded o. COUNTY o. STATE Maryland h. COUNTY Anne Arundel Anne arundel MARYLAND b. CITY OR TOWN (If ourside corporate limits, write RURAL and give nearest town)
Millersville c CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) c LENGTH OF STAY IN 16 Odenton, d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? Nevada Ave. Knollwood Nursing Home YES 🖂 NO X 3 NAME OF First 4. DATE Month Doy Year DECEASED 67 MEDLEY March 19 (Type or print) SUSAN CLAUDINE DEATH 9. AGE (In years IF UNDER 1 YEAR SEX IF UNDER 24 HRS 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 8. DATE OF BIRTH lost birthdoy) Months Doys Hours WIDOWED DIVORCED Feb. 15, 1882 white female. 100 USUAL OCCUPATION (Give kind of work done during most of working life, even if refired) 10b KIND OF BUSINESS OR 1) BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT COUNTRY? INDUSTRY Georgia never worked 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME signed by the ottending physi burial-tronsit permit. Then pl burial, cremation, or removal, Mary Jane Moss John William Jackson IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT Address (Yes, no, or unknown) (If yes give war or dates of service) Mrs. V. Kathryn Owens - Riva, maryland 214-54-9726 INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (o). by the hospital or attending physician. DUF TO Conditions, if ony, which gove rise to immediate cause (a), DUE TO stating the underlying cause os the l TO FUNERAL DIRECTOR: After this certificate has been fost. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 3 should be detoched for use with the State Dept. of Health YES [ NO 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED Enter noture of injury in Poff I or Port II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c TIME OF INJURY Month, Doy, Year foctory, street, office bldg., etc.) Not While of work ot work L 21. I certify that (I) (this haspital) attended the deceased fram. , 19\_\_\_, that (I) (we) last 19\_ \_\_\_\_, ta\_ 19 \_\_\_\_, and that death accurred at M, fram causes and an the date stated above. saw the deceased alive, an\_ 22b. DATE SIGNED 220. SIGNATURE MED DIRECTOR ATTENDING director, page 3 should be filed v M.D. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 230 BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) March 9.1967 Annapolis Hillcrest Cemetery 25h PEGISTRAR'S SIGNATURE 25o. REC'D BY REGISTRAR Hopping Charles VR A15 (4) 20 M 1/66 1967 HOPPING FUNERAL HORE -Annanolis. Mar Aland

Entra Contract

| MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |                 |   |   |  |   |  |  |
|---|-----------------|---|---|--|---|--|--|
| FOR STATE   |                 | 03077   | MEDICAL EXAMINER'S                      |  | 03067   |  |  |
| HEALT A DEPT.   | 1               | PLACE OF DEATH O COUNTY ANNE ARUN   | カミレ MARYLAND                            | 2 USUAL RESIDENCE (Where deceased lived, finst tution o STATE NARYLAND b. COUNT  |   |  |  |
| death If any de ay is a Pages 1, 2, and 3 to with farm PM3. Page be-State Department of 72 hours after death.   | 1               | or CITY OR TOWN (fourside corporate armits, write RURAL and gave nearest town)                      |   | CUTY OR TOWN (1) auts de corporate limits, write RURA  RURAL ANNAPOLI            | and give nearest town)                                  |  |  |
| - 4 0 ,   |                 | d. NAME OF HOSPITAL OR NSTITUTION (If not n $Best$ Fatz $K$   | hospital, give street address)          | BESTGATE RD.   | e is residence<br>On a farm?<br>Yes \( \) no            |  |  |
| after death<br>S. Give Page<br>plang with f<br>with the stat<br>within 72 ba  | 4               | NAME OF Prist PECEASED (Type or point)  | Y KAYLOR 1                              | METZGER 4 DATE Month OF DEATH MAN  | Doy Year<br>PCH £9 1967                                 |  |  |
| rs after<br>18. Giv<br>e along<br>2 with 1  | S               | MW  | MARRIED NEVER MARRIED DIVORCED DIVORCED | 8 DATE OF BIRTH  3 1884  9. AGE (In years  part pirthdoy)  yrs.                  | FUNDER I YEAR IF UNDER 24 HRS<br>Months Doys Hours Min. |  |  |
| 1 24 haurs<br>I in Item 18<br>er's Office<br>ges land 2 v<br>any event  | 10c             | . USUAL OCCUPATION (Give kind of work done many) of working line work retreated                     | 10b KIND OF BUSINESS OR                 | 11 BIRTHPLACE (State or foreign country)  MIDDLE TOWN PA                         | 12. CITIZEN OF WHAT                                     |  |  |
| J within 24 in pencil in Examiner's Examiner's File pages and in any  | 13.             | FATHER'S MAME HARRY K M2  | TZCER                                   | 14. MOTHER'S MAIDEN NAME FANNY CAYLOR  |   |  |  |
| executed within<br>anding" in pencil<br>Medical Examine<br>t permit. File pagi<br>emaval, and in a  |                 | WAS DECEASED EVER IN U.S. ARMED FORCES?<br>s, no, or unknown) (If yes give wor or doies of ser      |   | MARY C METZGE  | R #2  |  |  |
| MINER: This certificate should be executed within 24 hours after death if the certificate, writing the ward "pending" in pencil in Item 18. Give Pages 1, 4 should be farwarded to the Chief Medical Examiner's Office along with farm in files.  a should be used as a burial-transit permit. File pages land 2 with the State Degent, prior to burial, cremation, or remaval, and in any event within 72 hours.   |                 | 18. CAUSE OF DEATH (Enter only one couse p<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (o) _ | er line for (o), (b), and (c).)         | ruris gumulad  | INTERVAL BETWEEN ONSET AND DEATH                        |  |  |
| shauld be e<br>ne ward "per<br>a the Chief!<br>burial-transit<br>matian, or re  |                 | Conditions, if ony, which gove (b)  |   | <u> </u>   |   |  |  |
| certificate shauld<br>writing the ward<br>srwarded ta the C<br>used as a burial-tr<br>burial, crematian,  |                 | rise to immediate cause (a), stating the underlying cause last.                                     |   |  |   |  |  |
| This certificate cate, writing the farwarded to be used as a be used as a for the cate of | ATION           | PART II, OTHER S.GNIFICANT CONDITIONS CONTR   | IBUTING TO DEATH BUT NOT RELATED TO     | THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)                                | 19. WAS AUTOPSY PERFORMED? YES NO                       |  |  |
| INER: The certificate certificate should be files. 3 should be mut, prior t   | L CERT FICATION | 200 EXTERNAL CAUSE WAS PRIMARY □ or CONTRIBUTING □ CAUSE OF DEATH                                   | 206 DESCRIBE HOW INJURY OCCURRED        | (Enter nature of in any in Port or Port II of flem 18.)                          |   |  |  |
| EXAMINER: T<br>ute the certifica<br>age 4 should bb<br>your files.<br>Page 3 should   | MED.CAL         | 20c 71ME OF INJURY Month, Doy, Yeor<br>Hour o.m.<br>p.m. 19   |   | CE OF INJURY (Home, form, 2Df (City or town) tory, street, office bldg., etc.)   | (County) (State)  |  |  |
| _ 0 0 0 0 0 0   |                 | 2) I certify that I taak charge at<br>death resulted from Natural co                                | /                                       | eld an Autapsy 🔲 , Inspectian 🗂 , Inquir<br>cide 🗍 , Hamicide 🗍 Undetermined mai | A frank and a second and a second                       |  |  |
| Mercal Explores executed for your creations of the process of the |                 | ACTUAL SIGNATURE  |   | CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER                                | 22. DATE SIGNED   |  |  |
| o DEPUTY MNSTAL EXAM necessary, please execute the funeral director. Page 45 may be retained far yaur o FUNERAL DIRECTOR: Page Health ar its designated age   |                 | EXAMINER'S F. Lowh  | sedt.                                   | DEPUTY MEDICAL EXAMINER Address (Street, city, town, or county)                  | 3/21/67   |  |  |
| To D  | L               | Burial, cremation, 23b. Date thereo MAR 31  | 67 CEPAR B                              | LUFF CEM ANNAPOLI  | S AA.Co.M.D.  |  |  |
| VR ATSME (S)  | 2               | FUNERAL DIRECTOR CHAYLOR  | SON HINAPOLIS                           |  | STRARS SIGNATURE  |  |  |

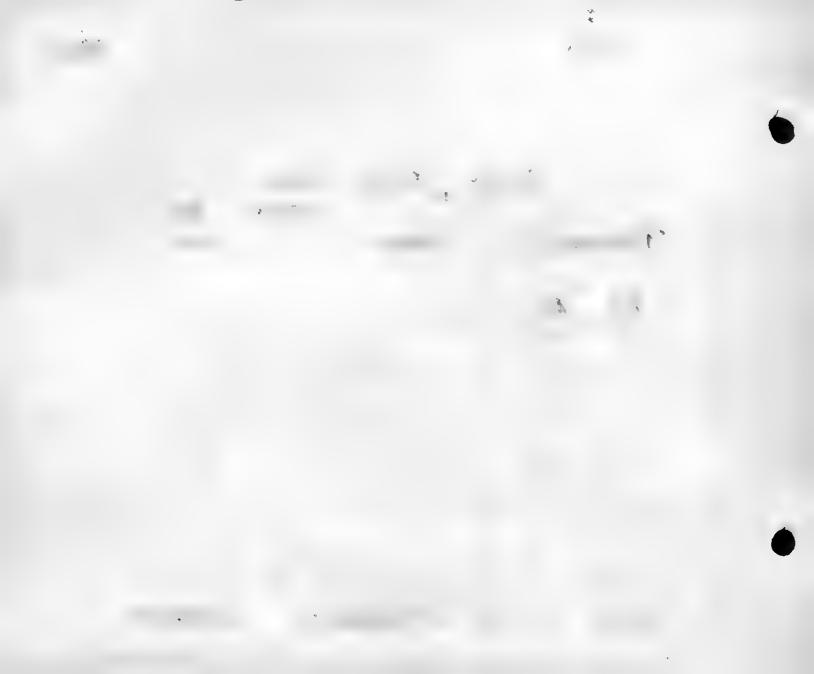


|  |                           |  |                    |   |                    |                                  | ND 21201                             | _                              |
|--|---------------------------|--|--------------------|---|--------------------|----------------------------------|--------------------------------------|--------------------------------|
| 03078  |                           | CERTIFIC                                   |                    | OF DEATH  |                    |                                  | 0306                                 | 3                              |
| 1 PLACE OF DEATH 0. COUNTY Anne Aru  | māol                      | MARYLA                                     |                    | . USUAL RESIDENCE (You state Maryla                   |                    | lived, if instituted<br>b. COUNT | n Residence befor<br>Y               | e admission)                   |
| b. CITY OR TOWN (If autside car<br>write RURAL and give neares   | parate imits<br>t tawn)   | 1 mon. 5                                   | li li              | CITY OR TOWN (If ou<br>Baltin                         | tside carparate l  | imits, write RURA                |                                      | 4                              |
| Crownsvi   |                           |  | d                  | STREET ADDRESS  |                    |                                  |                                      | e. IS RESIDENCE<br>ON A FARM?  |
| Crownsville 3 NAME OF  | State Hosp:               | ital<br>Middle                             |                    | 7 S. High   | Street             | Manth                            |                                      | YES NO XX                      |
| (Type or print) #34472   | Gordon                    | Clarenc                                    |                    | Miller  | OF<br>DEATH        | GE {In years                     | 5<br>IF UNDER 1 YEAR                 | 19 67<br>1 IF UNDER 24 HRS     |
| S. SEX 6. COLOR C  |                           | الإيما                                     |                    | /29/33  |                    | ost birthday)<br>33 yrs          | Months Doys                          | Hours Min.                     |
| 10a. USUAL OCCUPATION (Give kind or during most of warking life, even if re  | work done 10b.            | KIND OF BUSINESS OR INDUSTRY               |                    | 11 BIRTHPLACE (County                                 |                    | n country)                       | 12. CITIZEN O<br>COUNTRY             | 2                              |
| General Laborer  |                           |  | 1.                 | Tennesse 4 Mother's Maiden                            | NAME               | 41 -                             |                                      | USA                            |
| George Miller  | ED SORCES 1               | 6 SOCIAL SECURITY NO.                      | 17. INFO           | Myrtle  |                    | Addres                           | yell                                 | )                              |
| 15 WAS DECEASED EVER IN U.S. ARM (Yes, na, or unknown) (If yes give w  | ar or dates of service)   | Unknown                                    |                    | ospital Re  | cords              |                                  | 7                                    |                                |
| 18. CAUSE OF DEATH (Enter of   | only ane couse per line   | for (a), (b), and (c).)                    |                    |   |                    |                                  | INI<br>Oh                            | ERVAL BETWEEN<br>SET AND DEATH |
| 493X IMMEE   | DIATE CAUSE (a)<br>DUE TO | Pneumor                                    | 118                |   |                    | _                                |                                      |                                |
| Conditions, if any, which gave<br>rise to immediate cause (a),   | DUE TO                    |  |                    |   |                    |                                  |                                      |                                |
| stating the underlying couse last.   | (c)                       |  |                    |   |                    |                                  |                                      |                                |
| PART II. OTHER SIGNIFICANT CO  |                           |  |                    |   |                    | N PART 1(a)                      |                                      | WAS AUTOPSY PERFORMED? VES NO  |
| Chronic  20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING TICAUSE OF (If EITHER, NOTHEY MEDICAL EXA  20c. TIME OF INJURY Manth, Hour a.m. | G □ 20b.                  | drome due to DESCRIBE HOW INJURY OCCI      | Chro<br>URRED. (En | nic Alcoho<br>ter nature of injury in                 | Part I ar Port II  | of item 18.)                     |                                      |                                |
| 20c. TIME OF INJURY Month,<br>Hour a.m.  | Day, Year 20d             | I. INJURY OCCURRED  nile Not While at wark |                    | OF INJURY (Hame, farr<br>, street, affice bldg , etc. | )                  | City or town)                    | (County)                             | (State)                        |
|  | (this haspital) att       | ended the deceased fi<br>3/5/_19_67, ar    | ram                | 1/29/,<br>lenth accurred at                           | 19 <u>67</u> , to. | 3/5/<br>from couses of           | , 19 <u>.67</u> , t<br>and an the do | hat (I) (we) las               |
| 220. SIGNATURE   | 1/0                       | 1182                                       | *                  | ATTENDING -   | MED. DIRECTOR      | CTACC                            | 22b. DATE SIG                        | NED                            |
| 22c. PHYSICIAN'S NAME (Type) L.  | Benedict,                 | M.D.                                       | M.D                | PHYS. 22d. ADDRESS Crownsvil                          |                    |                                  |                                      |                                |
|  | Bb DATE THEREOF           | 23c NAME OF CEMET                          | ERY OR CRI         |   |                    | THON (City or Tay                |                                      |                                |
|  | E was / / ) was 7/1.      | / /// /                                    | 08///              | MACHEN LANGE  | D BY REGISTRAL     | CLA We                           | 100                                  | 1 6 11 13                      |

2 :

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 03073 PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. death, 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence the attending physician and campletely filled in by the funeral isst permit. Then please remove carban papers. Pages I and matian at removal, and in any event, within 72 haurs after deat PLACE OF DEATH before admission) p. COUNTY a. STATE b. COUNTY MARYLAND b CITY OR TOWN Of outside corporate limits, c. LENGTH OF STAY IN 16 CITY OR TOWN carparate limits, write RURAL and give nearest town ANNAPOLI write RURAL d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) e IS RESIDENCE ON A FARM? d. STREET ADDRESS NO T YES NAME OF Middle DATE Month Day Year Last DECEASED ARCH 19 DEATH (Type or print) 1 YEAR IF UNDER 24 HRS. SEX 6 COLOR OR RACE DATE OF BIRTH 9. AGE (In years IF UNDER 7 MARRIED **NEVER MARRIED** Manths Dovs Haurs à DIVORCED WIDOWED 12 CITIZEN OF WHAT 10a USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR during most of working life, even if retired) MOUSTRY ZANES VILLE 14 MOTHER'S MAIDEN NAME 13 FATHERS NAME UNKN 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 36, SOCIAL SECURITY NO. INFORMANT (Yes, ng. arunknawn) (If yes give war or dates of service) burial, crematian, INTERVAL BETWEEN OWSET AND DEATH CAUSE OF DEATH (Enter only one cause per line fet (a), (b), and (c)) burial-transit PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) signed by Page 4 may be retained by the haspital or attending physician. DUE TO Conditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying couse TO FUNERAL DIRECTOR: After this certificate has been director, page 3 shauld be detached far use as the shauld be filed with the State Dept, at Health priar ta last WAS AUTOPSY PERFORMED? 19. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) CERTIFICATION NO T 20a, ACCIDENT WAS UNDERLYING [ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER MED CAL 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (State) 20c. TIME OF INJURY Month, Day, Year factory, street, affice bldg., etc.) Hour a m Nat While 21. I certify that (I) (this haspital) attended the deceased fram and that death occurred at 2:30/M, from causes and on the date stated above. saw the deceased alive on 22b. DATE SIGNED 22a. SIGNATURI MED. DIRECTOR ATTENDING M.D. PHYS. PHYS 22d ADDRESS 22c PHYSICIAN'S NAME (Type) director, 23c NAME OF CEMETERY OR CREMATORY LOCATION (City of Town BURIAL, CREMATION 23b DATE THEREOF (Caynty) REGISTRAR'S SIGNATURE FUNERAL DIRECTOR 25g. REC'D BY REGISTRAR 25b. VR A15 (4)1 AYLORISONS MINNAPOLIS 198 20 M 1/66

| Division of STATISTICAL   | MARYLAND STATE DEP<br>L RESEARCH AND RECORDS, 301                      |  | LTIMORE, MARYLAND                 | 21201   |
|---|--|--|-----------------------------------|---|
| 03080   | CERTIFICATE  | OF DEATH   |                                   | 03070   |
| PLACE OF DEATH  O. COUNTY  Anne Arndel  | MARYLAND   | 2 USUAL RESIDENCE (Where de-<br>o. STATE M.d.          | P. COUNTA                         | Anne Hound  |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  d NAME OF HOSPITAL OR INST TUTION (If not in h | CLENGTH OF STAY IN 16  | Anapolis   | orote limits, write RURAL on      | d give neorest town)                              |
| d NAME OF HOSPITAL OR INSTITUTION (It not in h  | nospital, give street oddress) Homa                                    | d STREET ADDRESS RY 3 60                               | 7 27                              | e. IS RESIDENCE<br>ON A FARM?<br>YES NO           |
| 3 NAME OF DECEASED (Type or print) ROUND OR PACE 2 M  | Middle Downing   | MOORE OF DEA   | E Month                           | Doy Year<br>9 19 <i>67</i>                        |
| 5 SEX 6. COLOR OR RACE 7. W   |  | DATE OF BRYE   | 9 AGE (In years IF U)             |   |
| SEX 6. COLOR OR RACE 7. WI  JOS USUAL OCCUPATION (G ve kind of work done doring may be young a fretued)  13. FATHERS NAME       | 10b KIND OF BUSINESS OR INDUSTRIBLE                                    | 13 BIRTHPLACE (County & State, o                       |                                   | 2 CITIZEN OF WHAT COUNTRY?                        |
| 13. FATHER'S NAME   |  | 14 MOTHER'S MAIREN MAIN                                |                                   |   |
| E B (Tes, no, or unknown) (If yes give your or dotes at servi   | 16 SOCIAL SECURITY NO 17. IN  S65-14-3630                              | FORMANT<br>ROBERT BIERN                                | Address Address                   |   |
| 18. CAUSE OF DEATH (Enter only one couse per PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o)                                    | r line for (o), (b), and (c).) (ALDIAC TRESPIR                         | ATORY ARRES  | į.                                | INTERVAL BETWEEN<br>ONSET AND DEATH               |
| Conditions, if ony, which gove )  | benen 1. del cotorio   |  |                                   |   |
| rise to immediate couse (a), stating the underlying couse (bst. (c)   |  |  |                                   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIL   | BUTING TO DEATH BUT NOT RELATED TO TH                                  | IE TERMINAL DISEASE CONDITION G                        | IVEN IN PART 1(0)                 | 19 WAS AUTOPSY PERFORMED? YES NO                  |
| THE OF INJURY Month, Doy, Year Hour a.m.  | 206. DESCRIBE HOW INJURY OCCURRED (E                                   | nter noture of injury in Port I or                     | Port II of Item IB.)              |   |
| 2Dc. TIME OF (NJURY Month, Doy, Year Hour a.m. 19   | 20d. INJURY OCCURRED   20e. PLACE   While   Not While   foctor of work | OF INJURY (Home, form, ry, street, office bldg., etc.) | (City or town)                    | (County) (State)                                  |
| 21. I certify that (I) (this septial saw the deceased alive an  |  | death accurred at 2:34                                 | , ta,<br>⊉M, fram causes and c    | 19, that (I) (we) las<br>on the date stated above |
| 220. SIGNATURE R. Bree  | M D.   |  | STAFF 22                          | b. DATE SIGNED 3/9/27                             |
| 22c. PHYSICIAN'S NAME (Type) R. 3 1 E. R. NAME (Type) R. BJRIAI, CREMATION, 23b. DATE THEREOF REMOVAL (Society) 3               |  | 22d. ADDRESS   | 13 mos                            |   |
|   |  | Ets 17   | LOCATION (City or Town) MARGARETS | A.A. 12.  |
| 15 (4) 24 FÜNERAL DIRECTOR Taylor S   | ADDRESS ADDRESS  | 250. REC'D BY REG                                      |                                   | R'S SIGNATURE .                                   |



MARYLAND STATE DEPARTMENT OF HEALTH OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND CERTIFICATE OF DEATH USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) 1. PLACE OF DEATH a. COUNTY b. COUNTY MARYLAND c. CITY OR TOWN outside corporate limits, write RURAL and give nearest town b. CITY OR TOWN (if cutside corporate limits, write RURAL and give nearest town? tettruate Deach d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE d. STREET ADDRESS within 72 ON A FARM? NO X YES letely 3. NAME OF DATE Mon th Dav First Middie 4. DECEASED event, 1240627 DEATH 196 (Type or print) AGE (in years | IFUNDER 1 YEAR last birthday) | Months | Days 6. COLOR OF RACE 9. 7. MARRIED NEVER MARRIED and WIDOWED DIVORCED 12. CITIZEN OF WHAT 10a, USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR (County & State, or foreign country) = physician working life, even if retired) INDUSTRY **COUNTRY?** Maller ning certificate гетома attending principle of them 17. INFORMAN 15. WAS DECEASED EVER IN U.S ARMED FORCES? Ы death (Yes, no, or unkown) (If yes pive war or dates of service) INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Page 4 may be retained by the hospital or attending physician. DUE TO Conditions, If any, which been gave rise to immediate DUE TO cause (a), stating the underlying cause last. (c) 19. WAS AUTOPSY PERFORMED? PART III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION nesse NO 5 YES 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20a. ACCIDENT WAS UNDERLYING F OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20f. (City or town) (County) (State) 120e, PLACE OF INJURY (Home, farm, 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED factory, street, office bldg., etc.) Hour a.m. While Not While at work at work 21. I certify that (I) (this hospital) attended the deceased from. TO FUNERAL DIRECTOR: and that death occurred at 2 A.M. from the causes and on the date stated above. saw the deceased alive on, 22b. 22a. SIGNATURE director, page should be filed M.D. DIRECTOR PHYS. ADDRESS PHYSICIAN'S NAME (Type) LOCATION (City, town or county) BURIAL, CREMATION.I DATE THEREOF 23c. REMOYAL\_(Specify) Mar. 13.1967 Baltimore Cemetery Baltimore, Maryland buria ADDRESS 25a. REC'D BY REGISTRAR FUNERAL DIRECTOR George J. Gonce- 4001 Ritchie Hgwy., Baltimore VR A15 (4) 15M 4-64

A8 /A

Mo Carlos Maria Janas

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03082 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death funerol 1 and and PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY o. STATE b. COUNTY lease remove carbon popers. Pages 1 ond in any event, within 72 hours after Maryland Anne Arundel Anne Arundel MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 15 Pasadena Annapolis d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS Waterford Road S RESIDENC ON A FARM? completely filled Anne Arundel General Hospital 4. Box 85 NO Y NAME OF Middle 4 DATE Month Last Doy Year DECEASED Florence Marie MULLIGAN March 19 67 (Type or print) DEATH S. SEX 6. COLOR OR RACE 8 DATE OF BIRTH 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 7 MARRIED NEVER MARRIED lost birthdoy) Months Dovs Hours White WIDOWED DIVORCED X August 28, 1913 Female gud 10o ISUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State or fareign country) 12 CITIZEN OF WHAT physician o during most of working life, even if retired) COUNTRY? Maryland U. S. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME burial, cremotion, or removal, 17 INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO Address (Yes, no, or unknown) (If yes give wor or dates of service INTERVAL BETWEEN signed by the c burial-tronsit p 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b) and (c),) PART I. DEATH WAS CAUSED BY: ONSET AND DEATH evebra IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gove pertonsive lard ovapular disease rise to mimed ofe cause (a), DUE TO stoting the underlying couse by the hospital or attending rte rte hos been State Dept. of Health prior t lost. ds 19. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) use NO certificate ACCIDENT WAS JINDERLYING [ SESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20e. PLACE Of INJURY (Home, form, 20c TIME OF th JRY Month, Dov. Year 20d INJURY OCCURRED (City or town) (County) (Stote) Hour om factory, street, office bldg, etc.) Not While of work ot work O FUNERAL DIRECTOR: After 12. 1967, that (1) (we) last 2]. I certify that (!) (this hospital) attended the deceased fram Qui mace Poge 4 may be retained director, page 3 should should be filed with the saw the deceased alive on. march 1967, and that death foccurred at from couses and on the date stated above. 220 SIGNATURE 22b. DATE SIGNED ATTENDING M.D. PHYS. DIRECTOR PHYS 22c. PHYSICIAN'S 226. ADDRESS 3 ORS< VC NAME (Type) BURIAL CREMATION 23b DATE THEREOF 230. 250 RECD BY REGISTRAR 25b. REGISTRAR S SIGNATUR UNERAL DIRECTOR **ADDRESS** VR A15 (4) 25M 1/67



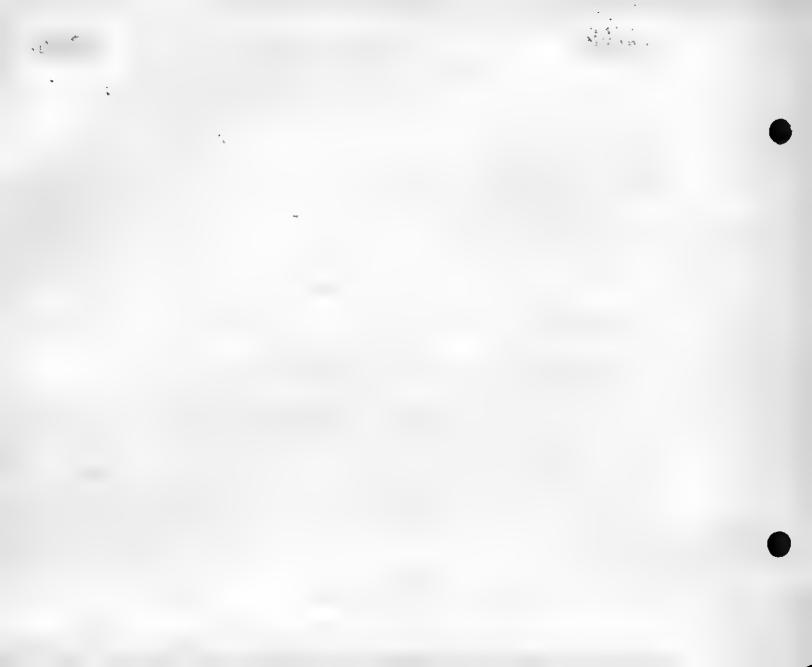
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03083 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceosed leved, if institution, Residence before admission) o. COUNTY o. STATE b COUNTY ely filled in by the fune bon popers. Poges 1 a , within 72 hours after d Anne Arundel Maryland Anne Arundel MARYLAND c EITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) b CITY OR TOWN (If ourside corporate imits, CLENGTH OF STAY IN 16 write RURAL and give nearest town) Glen Burnie Annapolis d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d STREET ADDRESS IS RESIDENCE ON A FARM? Anne Arundel General Hospital 7609 Marcy Drive YES NO NAME OF First Middle 4 DATE Last Month Doy Year DECEASED OF DEATH March NASH 19 67 (Type or print) Terry 20 Lynn evept S SEX 6 COLOR OR RACE NEVER MARRIED X 8. DATE OF BIRTH 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 7 MARRIED lost birthdoy) Months Days Hours June 29, 1956 WIDOWED DIVORCED White Female. 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b KIND OF 8USINESS OR 11 BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT INDUSTRY COUNTRY? attending physician termit. Then please Student Maryland U. S. 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME cremation, or removal, Donald T.Nash Vada Shipe 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no or unknown) (If yes give wor or doles of service) Donald T.Nash, 7609 Marcy Drive, Glen Burnie None 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c) ).
PART 1. DEATH WAS CAUSED BY. INTERVAL BETWEEN signed by the buriol-transit a ONSET AND DEATH IMMEDIATE CAUSE (o) Page 4 moy be retained by the haspital or ottending physician DUE TO Conditions, if any, which gove rise to immediate couse (a), DUE TO stoting the underlying couse os the last. PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COND.T:ON GIVEN IN PART 1(0) 19 WAS AUTOPSY PERFORMED? YES S NO F certificote 호 200 ACCIDENT WAS UNDERLYING [ 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 11 of Item 18) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Not While Hour 'o.m. foctory, street, office bldg, etc.) While to 3/20, 19 67, that (1) (we) last 1, fram causes and an the date stated above 21. I certify that (1) (this haspital) attended the deceased fram-3/20 director, page 3 should should be filed with the 312 P. 19:07, and that death accurred at FUNERAL DIRECTOR: saw the deceased alive an 22o. SIGNATURE 22b DATE S GNED ATTENDING M.D PHYS. DIRECTOR PHYS 22d, ADDRESS 22c. PHYSICIAN S O HOSPITAL NAME (Type) 23o. BURIAL, CREMATION, 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (Stote) (County) REMOVAL (Specify) Good Shepherd Ellicott City, Md 0 24 FUNERAL DIRECTOR REC'D BY REGISTRAR F.C. Higinbothom, Ellicott City. Mc



| . 1  |     |               | Di.   | irian of CTATICI                     |                          |                            |            | PARTMENT OF I                 |                     | ODE MADVI                    | AND 21201          |                                 |
|--|-----|---------------|---|--------------------------------------|--------------------------|----------------------------|------------|-------------------------------|---------------------|------------------------------|--------------------|---------------------------------|
| **   | /   |               |   | tems 8 &                             |                          |                            | - 21 1-0   | OFTEDEATH                     | KEEI, BALIIN        | IUKE, MAKTE                  | ANU 21201          |                                 |
| € 1  |     |               | 03084   | <u> </u>                             |                          | CER                        | IFICATE    |                               |                     |                              | 05                 | 074                             |
| - S 5 5 5  |     | T P           | LACE OF DEATH COUNTY                              |                                      |                          |                            |            | 2 USUAL RESIDENCE<br>a, STATE | (Where decease      | lived, if institut<br>b. COU |                    | admissian)                      |
| fter<br>fter<br>fter   |     |               | Anne A  | rundel                               |                          | C LENGTH OF ST.            | ARYLAND    | Mary                          |                     | During south BUI             | nne Arur           | del                             |
| rrs a<br>Page<br>urs a   |     | ľ             | CITY OR TOWN (If an write RURAL and giv           | re nearest town)                     | 5,                       |                            |            | ,                             |                     |                              | ~                  | e taway                         |
| hou hour sin b   |     | d             | NAME OF HOSPITAL O                                | OR INSTITUTION (If no                | at in haspital, g        | ive street address)        |            | Pasaden<br>d Street Address   | =                   | (Lake                        | Shore)             | IS RESIDENCE                    |
| requires that the death ceruficate be executed within 24 hours after death a physician.  I signed by the ottending physicion and campletely filled in by the function buriol-transit permit. Then please remove caban papers Pages 1 capa buriol-transit permit. The please remove caban papers Pages 1 capa buriol, commotion, or removal, and in any authin 72 hours after death | 1   |               | North A   | rundel                               | Hospit                   | al                         |            | Rt. # 7                       | Rox #1              | .68                          |                    | ON A FARM? YES NO               |
| d within   |     | 3. N          | AME OF<br>ECEASED                                 | Fi                                   | rst                      | Middle                     |            | Last                          | 4. DATE<br>OF       | Mant                         | h Day              | Year                            |
| e se e   | 1   | (1<br>S S     | ype ar print)                                     | COLOR OR RACE                        | D L D                    | C.                         |            | B DATE OF BIRTH               | DEATH               | March<br>AGE (In years       | 31 JE UNDER I YEAR | 19 <b>67</b><br>IF UNDER 24 HRS |
| e executed   |     |               |   |                                      | 7. MARRIED<br>WIDOWED    | NEVER MAR DIVO             |            | 10                            | 316                 | .ast birthday)               | Manths Days        | Haurs Min.                      |
| and e ex   | /   | 10a           | USUAL OCCUPATION (GI                              | <b>jhite</b><br>ve kind af wark dane | 10b KH                   | ND OF BUSINESS O           |            | May 31,19                     | ty & State, ar fare | 49 yrs                       | 12 CITIZEN OF      | WHAT                            |
| gte b<br>icion<br>leose<br>and i   |     | durin         | g mast af warking life,<br>Supervisa              | even if retired)                     |                          | oustry<br><b>teomerv</b> : | -Mard      | Marylan                       |                     |                              | COUNTRY?           |                                 |
| ufica<br>hysic<br>n ple  |     | 13.           | FATHÈR S NAME                                     |                                      |                          |                            |            | 14. MOTHER'S MAIDE            |                     |                              |                    |                                 |
| cert<br>The p  |     | 10            | Wilbur  | Nuebau                               | m lv s                   | OCIAL SECURITY N           | N 177      | Hele<br>NFORMANT              | n Mood              |                              |                    |                                 |
| ne death certifical ottending physici permit. Then ple ion, or removal, a  |     |               | WAS DECEASED EVER IN<br>, na, ar unknawn)  { ff y |                                      | if service)              |                            |            |                               |                     | Addre                        | 5                  | ame as                          |
| he d<br>perminen,  |     |               | YES IB. CAUSE OF DEATH                            | (Enter only one cou                  |                          |                            | 34 MTS     | Henryet                       | TRE E.              | Nusbaum                      | INT                | #2<br>RVAL BETWEEN              |
| of t<br>resit  |     |               | PART I DEATH V                                    | VAS CAUSED BY<br>IMMEDIATE CAUSE     | lia. t.                  | 2                          | andio      | I Infare                      | From                |                              | SONS               | SET AND DEATH                   |
| equires that the death certificate be executed physician. signed by the attending physicion and complet buriol-transit permit. Then please remove cat buriol, commotion, or removal, and in any exerting the property.   |     |               |   | DUE                                  |                          | 0                          | 3 +        | 0 -                           |                     |                              | .77                | Lac                             |
| quire<br>phys<br>signe<br>surio  |     |               | Canditions, if any, wh<br>rise ta immediate co    | I Intage                             | (b) <u>COLU</u>          | nary c                     | irler      | y wise a                      | se.                 |                              |                    | 162.                            |
|  |     |               | stating the underlyin<br>last.                    | ig cause DITE                        | Winter                   | rincles                    | otec A     | Lear De                       | riaae               |                              | Zinkm              | mn                              |
| the law re<br>ottending<br>hos been<br>se os the   |     | H             |   | ICANT CONDITIONS C                   | ONTRIBUTING T            | O DEATH BUT NOT            | RELATED TO | THE TERMINAL DISEASE C        | ONDITION GIVEN      | IN PART 1(a)                 | 19.                | WAS AUTOPSY<br>PERFORMED?       |
| r Thu<br>or of<br>te ha  |     | CERTIFICATION |   |                                      |                          |                            |            |                               |                     |                              | Y                  | S NO                            |
| YSICIAN: Ospital or certificate hed for unot hed for unot.   |     | RTIFIC        | 20a. ACCIDENT WAS UN<br>OR CONTRIBUTING (1)       |                                      | 20b. DES                 | CRIBE HOW INJUR            | OCCURRED.  | (Enter nature of injury i     | n Part I ar Part I  | l af item 1B.)               |                    |                                 |
| S PHYSICIAN<br>the hospital<br>this certifica<br>detached for<br>e Dept. of He   |     |               | (IF EITHER, NOTIFY MED<br>20c. TIME OF INJURY     | ICAL EXAMINER)                       | 204 IN                   | JURY OCCURRED              | 30° DIA    | CE OF INJURY (Hame, fa        | rm. 20f.            | (City ar tawn)               | (County)           | (State)                         |
| ATTENDING PHYSICIAN: The law restoined by the hospital or ottending CTOR: After this certificate hos been should be detached for use os the ith the State Dept. of Health prior to   |     | MEDICAL       | Haur a.m.   | Manin, Day, 1801                     | While                    | Nat While                  |            | ary, street, affice bldg., e  |                     | (City or Idwir)              | (county)           | (sigis)                         |
| DING<br>by th<br>Affer If<br>be de<br>State  |     | ŀ             | p.m.<br>21.   certify                             | that (I) (this has                   | at wark<br>pital) attend |                            | ed from    | MAY                           | 1962 ta             | MARCH                        | , 196 7. th        | at (I) ( <del>we)</del> last    |
| TEN<br>ined<br>ould<br>ould  |     |               | sow the dece                                      |                                      | FEB                      | 24 1967                    | _, and tha | t death accurred              | 145 145 14 M,       | from couses                  | and an the dat     | e stated above.                 |
| OR ATTENI DE retoined DIRECTOR: A ge 3 should ed with the  |     |               | 220 SIGNATURE .                                   | Louland                              | 1. d a                   |                            | MI         | ATTENDING                     | MED.                | STAFF                        | 22b. DATE SIGN     |                                 |
| y be r<br>y be r<br>DIRE   |     | -             | 22c PHYSICIAN'S                                   |                                      | or y                     | 7 :                        | M I        | D. PHYS. 22d. ADDRESS         | DIRECTOR L          | PHYS. L                      | 1 0                |                                 |
| PITA<br>mo<br>ERAL   | - / |               | NAME (Type) A                                     | RIHUR LAN                            | KFORD, J                 | R., M. D.                  | 2          | 934 mou                       | Main                | Kel bas                      | acteura, h         | rd.                             |
| TO HOSPITAL OR ATTENDING PH<br>Poge 4 may be retained by the h<br>TO FUNERAL DIRECTOR: After this<br>director, page 3 should be detac<br>should be filed with the State Dep  |     | 23a.          | BURIAL, CREMATION,<br>REMOVAL (Specify)           | 23b. DATE THE                        | EREOF                    | 23c NAME OF C              |            |                               |                     | TION (City or Tax            | 1 1 11             | ' '                             |
| 5 5 5 € £  | 0   |               | REMOVAL (Specify) LITE BL FUNERAL DIRECTOR        | April                                | 3,1967                   | Paltim                     | ore Na     | tional Ce                     | Halt                | imore.                       | Maryland           | 1                               |
| VR A15 (4) (<br>20 M 1/66  | W   |               | ingleton  | Funeral                              | Home                     | ADDRESS                    | ı mm f m   | DAM P                         |                     | 67 80                        | Carles Ja          | idge                            |



| (M) V  | 1             | Division of STATISTICAL  | MARYLAND STATE DEP<br>RESEARCH AND RECORDS, 301        |   |   | 21201  |
|--|---------------|--|--|---|---|--|
| i 2 d  |               | 03085  | CERTIFICATE  | OF DEATH  |   | 03075  |
| 24 haurs after death ad in by the funeral prers. Pages 1 and 172 haurs after death   | Ì,            | PLACE OF DEATH o. COUNTY  Anne Arundel   | MARYLAND   | 2. USUAL RESIDENCE (Where o. STATE Marylar                | b. COUNTY                               |  |
| ours after by the Pages  |               | b CTY DR IDWN (If outside corporate imits, write RURAL and give nearest tawn)  Crownsville                       | 1 yr. 10 mos.  | c CITY OR TOWN (If outside c                              | •                                       |  |
| Pers.  |               | d. NAME OF HOSPITAL OR INSTITUTION (IF not in h  | ,  | d STREET ADDRESS  |   | e. IS RESIDENCE<br>ON A FARM?<br>YES NO TO                     |
| thin pa  | 3.            | Crownsville State H  | Lucya Middle   | Sopel 4 8   | ATE Month                               | Doy Year   |
| ted wi   |               | DECEASED<br>(Type or print) #29558 Liuc  | ile Og   |   |   | 17 19 67<br>UNDER I YEAR   IF UNDER 24 HRS                     |
| execund camput campuser  | 100           | Female White W   | DOWED OIVORCED 100 KIND OF BUSINESS OR                 | 12/13/84<br>11. BIRTHPLACE (County & State                | 192 yrs                                 | nths Doys Hours Min.  12 CITIZEN OF WHAT                       |
| ate be<br>cian a<br>ease r   | dur           | , USUA, OCCUPATION (Give kind of work done<br>ing most of working life, even if refired)  Linknown FATHER'S NAME | INDUSTRY   | Poland _  | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | COUNTRY? USA   |
| physi<br>en pl<br>avat,  | 13            | FATHER'S NAME Unknown  |  | 14. MOTHER'S MAIDEN NAME Unknown                          |   |  |
| equires that the death certificate be executed within 24 hours after death. physician. signed by the attending physician and campletely filted to by the funeral burial-transit permit. Then please remove carban papers. Pages 1 and 2 burial, crematian, or remaval, and in any event, within 72 hours after death.  | 15.<br>(¥e    | . WAS DECEASED EVER IN U.S. ARMED FORCES?<br>es, no, or unknown) (If yes give wor or dotes of servi              | 18 SOCIAL SECURITY NO 17 (F<br>2/3-/5 7633-<br>Unknown | NFORMANT Hospital Recon                                   | Address                                 |  |
| at the at the at nist per  |               | 18 CAUSE OF DEATH (Enter only one couse per<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (o)                 | r line for (o), (b), and (c).)                         | a - Hypostatio  | 3                                       | INTERVAL BETWEEN<br>ONSET AND DEATH                            |
| es the sicion ed by al-tra   |               | 11221 DUE TO   | A 1  | clerotic Card   | iouscoules Die                          | 2000   |
| TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Page 4 may be retained by the haspital or attending physician.  TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely fill director, page 3 shauld be detached far use as the burial-transit permit. Then please remove carban p shauld be tiled with the State Dept af Health priar ta burial, crematian, or remayal, and in any event, within |               | rise to immediate couse (a), stating the underlying couse (b) DUE TO   | Arterios   | clerotic Caro.  | LOvascular Di                           | case   |
| TO HOSPITAL OR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the haspital or attending TO FUNERAL DIRECTOR: After this certificate has been director, page 3 shauld be detached for use as the shauld be filed with the State Dept af Health priar ta  | ATION         | PART II. OTHER SIGNIFICANT CONDITIONS CONTRI   |  | HE TERMINAL DISEASE CONDITION                             | N GIVEN IN PART 1(0)                    | 19 WAS AUTOPSY PERFORMED? YESNO                                |
| SICIAN<br>Spital of<br>ertificat<br>ed far<br>ed far   | CERTIFICATION | 200. ACCIDENT WAS UNDERLYING ☐<br>OR CONTRIBLTING ☐ CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)       | 205. DESCRIBE HOW INJURY OCCURRED (                    |   | or Port II of item 18.)                 |  |
| SPITAL OR ATTENDING PHYSICIAL 4 may be retained by the haspital VERAL DIRECTOR: After this certifica for, page 3 shauld be detached for Id be filed with the State Dept af He  | MEDICAL       | 20c. TIME OF INJURY Month, Doy, Year<br>Hour o.m.<br>p.m. 19   | While Not While of work of work                        | E OF INJURY (Home, form, ory, street, office bldg., etc.) | 20f. (City or town)                     | (County) (State)   |
| TENDIA<br>Inned by<br>OR: Affe<br>Avuld be<br>the Sto  |               | 21. I certify that (I) (this hospital saw the deceased alive stry ) 3  | ) attended the deceased fram                           | 5/20/, 19_6<br>death accurred at_1:                       | 5 , ta 3/17/<br>55 M, fram causes and   | , 19 <u>67,</u> that (I) (we) last<br>an the date stated abave |
| OR AT:<br>OR AT:<br>OR refail<br>OR refail<br>OR she ded with  |               | 220 SIGNAFORE LEVEL A  | 15in 1/4/2/2 M.D                                       |   | — STAFE —                               | 226. DATE SIGNED<br>3/17/67                                    |
| PITAL may be RAL D   |               | 22c PHYSICIAN'S<br>NAME (Type) Lionel McHer  | nry Mapp, M.D.   |   | State Hospita                           | l, Maryland  |
| O HOS Page 4 O FUNI Shaulo   | 236           | BURIAL (REMATION, REMOVAL (Specify) 23b DAYE THEREOF   | 67 HOLY ROS  | ARY   | DALTO.                                  | (Sounty) (Stote)   |
| VR A15 (4)   | 24            | 4 FUNERAL DIRECTOR OHN) M. WEBER VSG   | address INIC. 401 S.C                                  | 250. REC'D BY R HESTER POATE IN MIT                       |   | car's signature Judge  |
|  | <u> </u>      |  |  | 57.   |   |  |





MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03087 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 haurs after death 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before PLACE OF DEATH o. COUNTY b. COUNTY Ma ryland A. A. Anne Arundel MARYLAND b (ITY OR TOWN (If outside corporate imits, write RURAL and give neorest town)
Glen burnie c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 Rivier a Beach d STREET ADDRESS d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) IS RESIDENC ON A FARM? 8139 Church Road North Arundel General Hospital 3 NAME OF First Middle 4 DATE Month Year DECEASED FREDERICK March 7. PARR (Type or pnnt) DEATH IF UNDER 24 HRS. S SEX 6. COLOR OR RACE NEVER MARRIED B DATE OF BIRTH 9. AGE (in years IF UNDER 1 YEAR 7. MARRIED last birthday) Male White Aug. 31, 1894 and in any WIDOWED DIVORCED 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT 10o. US JAL OCCUPATION (Give kind of work done 10h KIND OF BUSINESS OR COUNTRY? during most of working life, even if retired)
Bank Ressenger Equitable Trust New York, N. Y. 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME ar remaval IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service) 053-03-8176 Mrs. Helen Parr signed by the attent burial-transit permit burial, crematian, a Same IB. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c) ) INTERVAL BETWEEN ONSET AND DEATH PART I DEATH WAS CAUSED BY cas cular IMMEDIATE CAUSE (o) **DUE TO** Conditions, if ony, which gove 3 rise to immediate couse (o), **DUE TO** stoting the underlying cause WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO K O FUNERAL DIRECTOR: After this certificate 20o. ACCIDENT WAS UNDERLYING [ 205. DESCRIBE HOW INJURY OCCURRED, (Enter noture of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (State) 20c. TIME OF INJURY Month, Doy, Year Hour om. factory, street, office bldg., etc.) Not While of work of work L pital) attended the deceased fram 3 / 7 , 1967, 10 3 / 7 , 1967, that (I) (we) last 3 / 7 / 67 19 , and that death accurred at 9 M, fram causes and an the date stated above. 2), I certify that (I) (this haspital) attended the deceased fram 3/7 Page 4 may be retained saw the deceased alive an \_\_\_ 22a. SIGNATURE 22b. DATE SIGNED ATTENDING PHYS. DIRECTOR M.D. , 22d ADDRESS 22c. PHYSICIAN'S LOO Crain Hwy. N. W. Glen Burnie, Md. Robert Dabolins NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION, 23b DATE THEREOF 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) Glen burnie. Maryland March 10, 1967 Glen Haven Cemetery 24 FUNERAL DIRECTOR LOOI Ritchie Hwy. George J. Gonce



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03088 CERTIFICATE OF DEATH requires that the death tertificate be executed within 24 haurs after death USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) the attending physician and completely filled in by the funeral sit permit. Then please removertarban papers. Pages I/and mation at remaval, and in any evept, within 72 haurs after dead 1. PLACE OF DEATH Anne Arundel o. COUNTY o. STATE b. COUNTY MARYLAND b CITY OR TOWN (If autside carparate mits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 (CITY OR TOWN (If outside corporate limits, write RURAL and give negrest tawn) 27 vrs. 3 mos Washington D. C. d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS E. Capitol Street e. IS RESIDENCE ON A FARM? NO Children's Center Hospital YES 3. NAME OF Last 4 DATE Day Year DECEASED 19 67 (Type or print) DEATH Randal: IF UNDER I YEAR March Male IF UNDER 24 HRS. NEVER MARRIED AGE (In Years last birthday) Manths Hours DIVORCED WIDOWED 7 - 10 - 2712 CITIZEN OF WHAT 10g USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 1) 81RTHPLACE (County & State, or fareign country) during most of working life, even if retired) **COUNTRY?** INDUSTRY Institutionalized
13. FATHER'S NAME **JISA** Pennsylvania

14. MOTHER'S MAIDEN NAME Carrie Randall 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no ar unknown) (Iff yes give war ar dates of service Children's Center Hospital, Laurel, Md. INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) signed by the burial-transit p SANSET AND PEATH PART I. DEATH WAS CAUSED BY Chronic nephrosclerosis IMMEDIATE CAUSE (a). MYOX DUE TO Acute gastric distention Canditians, if any, which gave rise to immediate cause (a), **D**UE TO stating the underlying couse Page 4 may be retained by the haspital or arrenaing TO FUNERAL DIRECTOR: After this certificate has been as the Softening of 9th thoracic certerbrae - possible neorphlast PART H. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? YES IX NO F Moderate degree of cirrhosis - (suspect)
a ACC DENT WAS JNDERLYING | 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) fg 200 ACC DENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Manth, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or town) (Caunty) (State) factory, street, affice bldg., etc.) Nat While 21. I certify that (I) (this haspital) attended the deceased fram December / , 1939, to March 25, 1967, that (I) (we) last saw the deceased glive an March 25 19 67, and that death accurred at : 40n M, from causes and an the date stated above 220 SIGNATURE 22b. DATE SIGNED ATTENDING PHYS STAFF PHYS. M.D. DIRECTOR 3/29/67 22d. ADDRESChildren's Center, Laurel, Md. 22c. PHYSICIAN'S E. BOYLAND. NAME (Type) directar, 23d LOCATION (City or Town) 23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. 3AJE314ERE867 CHAME OF GIVETERY OF CRIMATORY (County) (State) Md. Laurel 25b REGISTRAR'S SIGNATURE FUNERAL DIRECTOR **ADDRESS** 2So. REC'D BY REGISTRAR Melianella

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH PLACE OF DEATH USUAL RESIDENCE (Where deceased ) yed if institution Residence before admission) a COUNTY **D STATE** P COUNTY Page 0 ō after death MARYLAND Department c CITY OR TOWN (if autside corporate mils, write RURAL and give nearest tawn) b CITY OR TOWN (If outside corporate limits, C LENGTH OF STAY IN 1b 2, u. p.m3 d NAME OF HOSPITAL OR INSTITUTION ( finat in hospital, give street address) d STREET ADDRESS 72 haurs o Office o.ong with form ON A FARM? 104 Ralph. Run YES NO DR 3 NAME OF First Middle 4 DATE Month DECEASED MANUde (Type or pant) DEATH 19 S SEX 9 AGE (In years IF UNDER 1 YEAR 6 COLOR OR RACE DATE OF BIRTH IF UNDER 24 HRS 7 MARRIED NEVER MARRIED lost birthday) Months Dovs Haurs. DIVORCED 10a USUA, OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OF 11 BIRTHPLACE (State or fareign country) 12 CIT ZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY Chief Medical Examiner's Gny NUMBUING 13 FATHER'S NAME 14 MOTHER'S MA DEN NAME be executed within  $\subseteq$ puo 16 SOCIAL SECURITY NO 17 INFORMÁN WAS DECEASED EVER IN U.S. ARMED FORCES: (Yes, no, or unknown) (If yes give wor or dotes of service) or removal, 068-18-6070 18. CAUSE OF DEATH (Enter on y one couse per line for (o), (b), and (c).) INTERVAL BETWEEN buriol-tronsit ONSET AND DEATH PART ! DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) This certificate should cremotion, DUE TO Conditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying cause burial, a last. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART 1(6) 19 WAS AUTOPS) PERFORMED? NO DO designated agent, prior to 20o EXTERNAL CAUSE WAS 20b DESCRIBE HOW INILRY OCCURRED (Enter noture of injury in Port I or Port II of tem 18) PRIMARY I or CONTRIBUTING I CAUSE OF DEATH ₹ 20c TIME OF INJURY Manth, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form 20f (City or town) (County) (State) Hour om Not While factory, street, office bldg .etc ) pleose execute ot.work 21. I certify that Ltack charge of the remains described above, held an Autopsy Inquiry . Į. Inspection and in my opin an death resulted fram. Natutal couses -Accident Suicide Homicide Undetermined manner be retained CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE FUNERAL the funeral TO DEPUTY 5 moy be I TO FUNERAL Health or it DEPUTY MEDICAL EXAMINER **EXAMINER'S** NAME (Type) Address (Street, city, town, or county) 23c NAME OF CEMETERY OR CREMATORY BURIAL CREMATION DATE THEREOF 23d LOCATION (City or Town) (Stote 250 REED BY REGISTRAR FUNERAL DIRECTOR VR A15ME (5) 1967 DATE 6M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03090 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before odmission) o. COUNTY Arundel Maryland MARYLAND Aime Arundel b CITY OR TOWN (If outside carparate mits, write RURAL and give nearest town)
Clen Burnie c LENGTH OF STAY IN 16 c CITY OR TOWN (If outside carporate limits, write RURAL and give negrest town) 24 days Severn d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? North Arundel Hospital Box 112-B Rt. YES NO X NAME OF Middle First Last 4 DATE Month Doy Year DECEASED (Type or print) Ethel Ray 3 DEATH S. SEX DATE OF BIRTH 6 COLOR OR RACE 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 7 MARRIED NEVER MARRIED female white last, byrthday) Months Days Haurs 3-26-92 WIDOWED DIVORCED pao 100 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) 12 CITIZEN OF WHAT signed by the ottending physician or buriol-transit permit. Then please buriol, cremation, or removol, ond in Baltimore, XXXXXXXXXXXXXXXX duting most of working life, even if retired) INDUSTRY COUNTRY? U.S.A. Own Home housewife
13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME Hamilton Jessie Edward Nunn 15 WAS DECEASED EVER IN U.S. ARMED FORCES?
[Yes, no, or unknown] [(If yes give wor or dates of service) 17 INFORMANT 16. SOCIAL SECURITY NO Address Willis A. Ray. Sr., same as 2 INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (of, (b), and (c).) PART I, DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4200 DUE TO Conditions, if any, which gave rise to immediate couse (o), DUE TO os the prior to stating the underlying cause O FUNERAL DIRECTOR: After this certificate has been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) WAS AUTOPSY PERFORMED? YES NO 20g ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER! (City or town) 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (County) (State) factory, street, affice bldg., etc.) at work 21. I certify that (1) (this haspital) attended the deceased fram Ite MUS deceased fram Jeffeld , 1923 to Jeffeld W., 1961, that (1) (we) last 1967, and that death accurred at 250 M, fram causes and on the date stated above. saw the deceosed alive on... 22a SIGNATURE 22b. DATE SIGNED ATTENDING DIRECTOR M.D. PHYS. 22c. PHYSICIAN S 22d. ADDRESS NAME (Type) Dr. C.R. MacDonald P.O. Box 700 Glen Burnie, Md. director, should 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23a. BURIAL, CREMATION 23b. DATE THEREOF (County) (Stote) REMOVAL (Specify) Anne Arundel Co., Md. Friendship Cemetery 22 March 67 Burial 256 REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR 25g. REC'D BY REGISTRAR VR A15 (4) 20 M 1/66 Kirkley Funeral Home, Glen Burnie, Md.

| I  | MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  |
|--|--|
| STATE  | 03091 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No. 03081   |
| H DEPT.  | 1. PLACE OF DEATH a. COUNTY A. F. Co.  MARYLAND  2. USUAL RESIDENCE (Where deceased lived 15 institution: Residence before admiss on) b. COUNTY A. F. Co.  MARYLAND  |
|  | b CITY OR TOWN 1 outside corporate limits, write EURAL ond give nearest town)  ANDA-POLIS  C. LENGTH OF STAY IN 1b  C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Convenience of the conve |
| Ai   | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress)  O. H - HanE Alecodol. Gens. Rt. 2 Box 406  VES 17 NO   |
|  | 3. NAME OF DECEASED (Type or print) William REINERT DEATH 3 11 19 7  |
| 4  | 5. SEX  6. COLOR OR RACE 7 MARRIED   B DATE OF BIRTH  9 AGE (In years lift UNDER 14EAR IF UNDER 24 HRS log b) b) b)   Months   Days   Hours   Min.   |
| The state of the s | 10a USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State or foreign country)  112 CITIZEN OF WHAT COUNTRY?  123 CITIZEN OF WHAT COUNTRY?  134 CITIZEN OF WHAT COUNTRY?   |
|  | 13. PATHER'S NAME  14. MOTHER'S MAIDEN NAME  14. MOTHER'S MAIDEN NAME  14. MOTHER'S MAIDEN NAME  |
|  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT  Address  Office of the property of the prop |
|  | 18 CAUSE OF DEATH [Enter only one couse per fine for (a), (b), and (c) ]  INTERVAL BETWEEN ONSET AND DEATH   |
| 5  | PART 1. DEATH WAS CAUSED BY:  MMEDIATE CAUSE (a)  LULISTE CHEST  DUE TO  |
|  | Conditions, if ony, which agree rise to immediate cause (b)  |
|  | (a), stating the underlying OUE TO cause fast. (c)   |
| ž.   | PART IE. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19. WAS AUTOPSY PERFORMED?  YES NO THE PART IE. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19. WAS AUTOPSY PERFORMED?  YES NO THE PART IE. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19. WAS AUTOPSY PERFORMED?  |
|  | 206. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CONTRIBUTING CONTRIBUTING CONTRIBUTING CONTRIBUTING CONTRIBUTING CONTRIBUTING CONTRIBUTING CONTRIBUTIONS CON |
|  | 20c TIME OF INJURY Month, Day, Year Annual Poly Month, Day, Year Annual Poly Mile Not while of work of |
|  | 21. I certify that I took charge of the remains described above, held on Autopsy . Inspection . Inquiry . and in my  |
|  | opinion deoth resulted from. Notural causes . Accident . Suicide . Homicide . Undetermined monner  |
|  | ACTUAL SIGNATURE MD. CHIEF MEDICAL EXAMINER DATE SIGNED  |
|  | EXAMINER'S 15  |
| ,<br>*   | NAME (TYPE) L. L. W. 1.47 COT . DEPUTY MEDICAL EXAMINERS 3-11-67  220 BYRIAI CREMATION 7226 DATE THEREOF [22c. NAME OF CEMETERY OF CREMATORY [22d. LOCATION City, town of county] ISIO(4)  |
|  | General 3-14-67 Epistam Cem. (Colentin Sud   |
| cR   | 23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS J 246 REC'D BY REGISTRAR'S SIGNATURE SUPERAL DIRECTOR'S SIGNATURE SUPERAL DIRECTOR |
| to   | POBERT & BARRANCO MA   |

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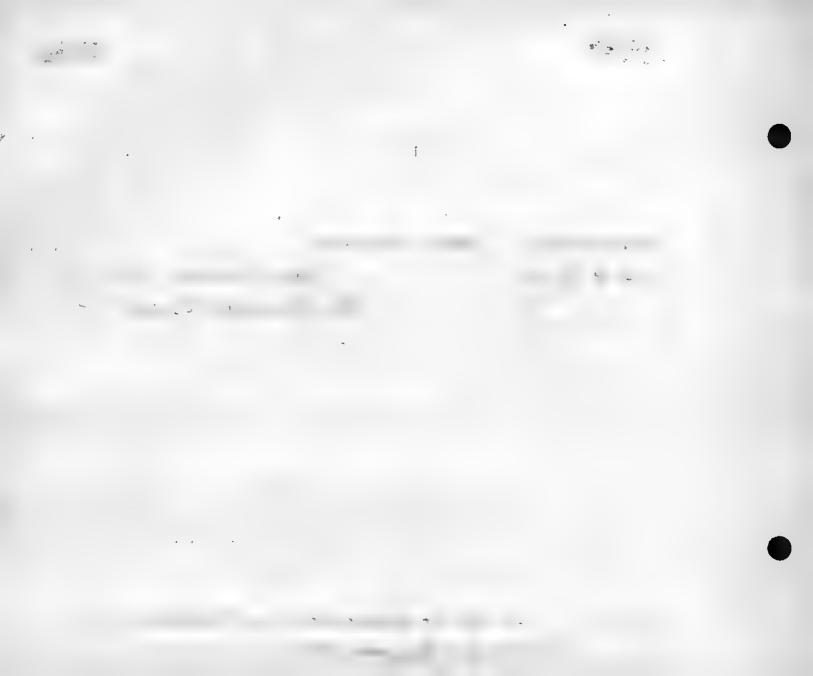
| 1 1  |   | .AND STATE DEPARTMENT OF HEALTH<br>ND RECORDS, 301 W. PRESTON STREET, BAI | LTIMORE, MARYLAND 21201  |
|--|---|---|--|
| - 2.   | 03092   | CERTIFICATE OF DEATH  | 03082  |
| Page 4 may be retained by the hospital or otherding physician.  To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and priory event, within 72 hours after death.   | PLACE OF DEATH O. COUNTY Anne Arundel   | MARYLAND O. STATE Marylan   |  |
| 24 hours after d in by the pers. Pages 72 hours after  | write RURAL and give nearest town) Annapolis  | day RURAL -   | orote limits, write RURAL and give nearest town)  Arnold   |
| filled in 19 hours. Thin 72 hours.   | d NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street  Anne Arundel General Hospital                 | d. STREET ADDRESS  Rt-1, Box-34   | e. IS RESIDENCE<br>ON A FARM?<br>YES NO I  |
| d within 2 etely filled arbon polynthin it, within   | 3. NAME OF DECEASED (Type or print) TERECA AN   | Middle Los? 4. DAT OF OF RICKERT DEA'                                     | E Month Day Year   |
| the death certificate be executed with the attending physician and completely for it permit. Then please remove carbon mation, or removol, and prony event, with   | Female White WIDOWED  | EVER MARRIED (2 8. DATE OF BIRTH  DIVORCED (1 Mar. 17, 1967)              | 9. AGE (n years   IF UNDER ! YEAR   IF UNDER 24 HRS   If UNDER 2 |
| ician an   | 10a US.AL OCCUPATION (G ve kind af work dane during most of working life, even if retired)  Newborn               | Anne Arundel,   | I COUNTRY 2  |
| eath certifica<br>ending physi<br>nit Then pl<br>or removol,   | 13 FATHERS NAME   | 14. MOTHER'S MAIDEN NAME.   | History  |
| death<br>untendin<br>ermit<br>n, or re   | 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, grunknown) (If yes give wor ar dates of service)            | John of L.  | chart alexan   |
| thot the d<br>on.<br>by the att<br>tronsit per<br>cremation,   | 18 CAUSE OF DEATH (Enter only one couse per line for (a), (b), (PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) | and (c))  | INTERVAL BETWEEN<br>ONSET AND DEATH  |
| The low requires that the ottending physicion. has been signed by the se as the burial-transit the prior to burial, cremate.   | Conditions, if any, which gave (b)  |   |  |
| The low recontending to the box been size as the by the prior to be the content of the beautiful to the beau | stating the underlying cause lost.  | naturity  | LID MACAUTANE  |
| AN: The old or otte ficote hos for use a Health pr   | PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH  | <u> </u>  | YES NO NO  |
| YSICIAI<br>ospitol<br>certific<br>thed for   | OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   | OW INJURY OCCURRED (Enter nature of injury in Port I or I                 | ·  |
| Page 4 moy be retained by the haspital or of the Page 4 moy be retained by the haspital or of the FUNERAL DIRECTOR: After this certificate hadirector, page 3 should be detached for use should be filed with the State Dept. of Health  | p.m. 17 gr wark 🗀 at  | t While foctory, street, affice bldg., etc.)                              |  |
| R ATTENDI<br>retoined b<br>RECTOR: Af<br>3 should b<br>with the S  | 21. I certify that (I) (this kaspital) attended the saw the deceased alive an 3-120. SIGNAPORE //                 | deceased fram 3-17, 1967, 1967, and that death accurred ar                | ta 3-18, 1967, that (I) (we)cla M, from causes and an the date stated abav 3:20PM) 1 22b. DATE SIGNED  |
| L OR A be reth birder birder iled with   | 22c PHYSICIAN'S   | M.D. ATTENDING MED. DIRECTOR  22d. ADDRESS                                | STAFF TO TO 10   |
| O HOSPITAL OR<br>Page 4 moy be 1<br>O FUNERAL DIRI<br>director, page 3<br>should be filed v  | NAME (Type) Clayton Nor   | ton Severna   | Park, Md.  LOCATION (City or Town) (Caunty), (State)   |
| - X  | REMOVAL (Specify)   | ADDRESS 250. REC'D BY REGI  | Tratte like the  |
| VR A15 (4)   | that I thream dever   | ~ 14. 14 ( MAR 27   | 1967 Planles Judge   |



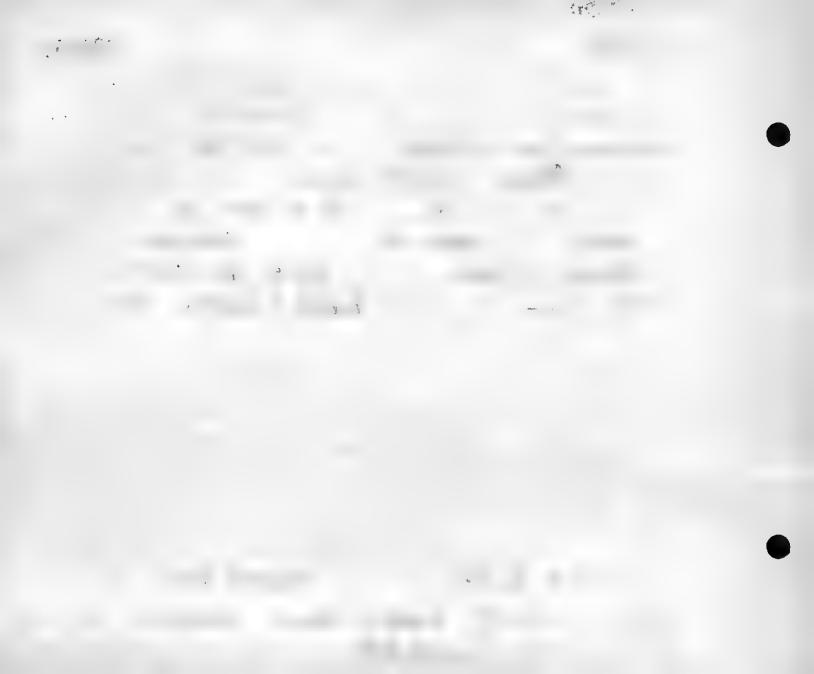
|                       | -03093   | 3                                  |  | CERTIF   | ICATE OF  | DEATH  |                       |   |
|-----------------------|--|------------------------------------|--|--|---|--|-----------------------|---|
| 1,                    | PLACE OF DEAT  | H                                  | _  |  | 2, USUAL  | RESIDENCE (Where   | daceased livad, If I  | institutioni Residenc   |
|                       | a. COUNTY AND  | IĒ ARUN                            | IDET.  | MARY   | a. STATE  | MARYLAND   | b. COUN               | ITY ANNE AF   |
|                       | b CITY OR TOWN   | (if outside corpo                  | rata limits,   | e. LENGTH OF STA   |   | OR TOWN (If outside co   | rporate limits, write | RURAL end give n  |
|                       |  | nd giva nearest k<br><b>avelis</b> | own)   | Life   |   | Annapelis  |                       |   |
| _   ~                 |  |                                    | UTION (if not in h   | ospital, give street addr  | d. STREE  | T ADDRESS  | _                     |   |
| 1                     | 1910 West.   | Street                             |  |  | 1910  | West Stre  | et                    |   |
|                       | NAME OF  |                                    | First  | Middla   | Last  | T4 DATE  | Month                 | n Day   |
|                       | (Type or print)  |                                    | DOROTHY  | PARKER   | SAVOY   | OF<br>DEAT   | H March               | 31-   |
| 5.                    | SEX  | 6 COLOR O                          |  | LIED NEVER MARRIE  |   | тн   | 9. AGE (In years      |   |
| II.                   | cmale  | Negro                              |  | VED TATA DIVORCE   | - 7/  | -1892  | 75 yrs.               | Months Days   |
| 10                    | a. USUAL OCCUPA  | TION (Giva kind                    | d of work 10b  | KIND OF BUSINESS OR  |   | ACE (County & State,   | or foreign country)   | 12. CITIZEN OI  |
| ď                     | one during most of w   |                                    | n if rehred)   | ******   | Anne  | Arundel Co   | Marvlan               | ad U.   |
| 13                    | . FATHER'S NAME  |                                    |  |  |   | 'S MAIDEN NAME   | ,                     |   |
|                       | Cale   | riel Pa                            | ırker  |  | Mar   | rtha Ann Go  | le                    |   |
|                       | . WAS DECEASED E   | VER IN U.S. ARA                    | MED FORCES?   1  | 6. SOCIAL SECURITY N   | 0. 17. INFORMANT  |  | Addrass               | -   |
|                       | as, no, or unkown)   | (if yes giva war or                |  | 7 2 7 2 7 2  | # Deneth  | Savey-1910   | West St               | . Arma. l   |
|                       | NO CAUSE OF  | DEATH (Faler                       |  | 212-18-0980<br>or tine for (a), (b), and (c  |   | A DEAD -TATE   | O HOSU DO             | LINI  |
|                       |  |                                    |  |  | 2 1   |  |                       | ON  |
|                       | PART! EA   | TH WAS CAUSE                       | ED 8Y:   | Kellenst   | - Odlar   | 7 / Me   | ors o                 |   |
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| CAL CERTIFICATI       | Conditions, f ar geve rise to imme tell, stating the causa last.  PART II. OTH  20a ACCIDENT NOTE  20a ACCIDENT NOTE  20a ACCIDENT NOTE  20c TIME OF IN. Hour e.m. p.m  21. I cartify saw the dece  22a SIGNATURE  | IMMEDIATE CA                       | DUE TO  (c)  (c)  (c)  (c)  (c)  (c)  (c)  (c  | ONTRIBUTING TO DEAT  DESCRIBE HOW INJURY  DESCRIPTION  DESC | H BUT NOT RELATED TO  OCCURED (Enter natura  20e. PLACE OF INJURY taclory, straet, offi  d from   | of injury in Peri I or Pari<br>(Home, farm, 20f. (Con bidg., atc.))  19, to pured at   | E CONDITION GIV       | (County)  |
| MEDICAL CERTIFICATI   | Conditions, f ar geve rise to imme tell, stating the causa last.  PART II. OTH  20a ACCIDENT OF CONTRIBUTIN (IF EITHER, NOTIF EITHER,  | IMMEDIATE CA                       | DUE TO  (c)  DUE TO  (c)  CONDITIONS CO  DEATH AMINER  Day, Year  Poly Aller   | ONTRIBUTING TO DEAT  DESCRIBE HOW INJURY  Ed. INJURY OCCURRED  Tille Not While  Tork at work a | H BUT NOT RELATED TO  OCCURED (Enter natura  20e. PLACE OF INJURY taclory, straet, offi  d from   | of Injury in Peri I or Pari<br>(Home, farm, 20f. (Consultation) 19, from the parish of the parish o  | E CONDITION GIV       | (County)  (County)  19, 19, 11  and on the da                   |
| MEDICAL CERTIFICATI   | Conditions, f at geve rise to imme le), stating the causa last.  PART II. OTH  20a ACCIDENT OF CONTRIBUTION (IF EITHER, NOTIFE 20c. TIME OF IN. Hour e.m. p.m  21. I cartify saw the dece  22a SIGNATURE  22c PHYSICIAN NAME (Typ.)  | IMMEDIATE CA                       | AUSE (e)  DUE TO  (c)  T CONDITIONS CO  DEATH AMINER)  Day, Year  19  Aller  ATE THEREOF   | ONTRIBUTING TO DEAT  DESCRIBE HOW INJURY  Ed. INJURY OCCURRED  Tille Not While  Tork at work a | H BUT NOT RELATED TO  OCCURED (Enter natura  20e. PLACE OF INJURY factory, straet, offi  d from  M.D. PHYS. 22d. AI  EMETERY OR CREMATO | of injury in Peri I or Pari  (Home, farm, 20f. (Control of Injury in Peri I or Pari  ( | E CONDITION GIV       | (County)  (County)  19, 19, the and on the date with or county) |



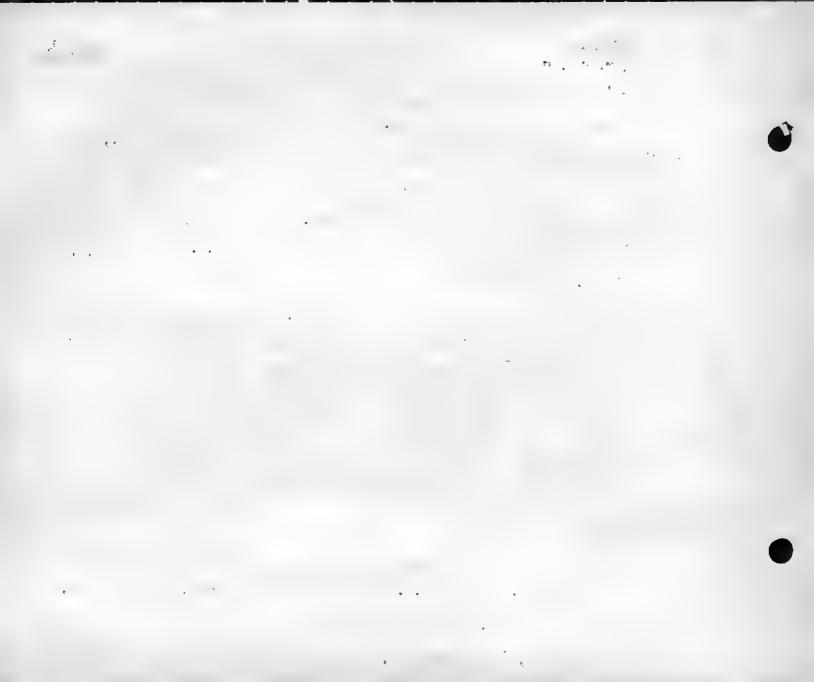
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03094 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) PLACE OF DEATH o. COUNTY o. STATE **b.** COUNTY Anne Arundel Maryland MARYLAND Anne Arunde l b CITY OR TOWN (If outside corporate limits, c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 write RURAL and give nearest town) Annapolis Annapolis d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS Box 1 ON A FARM? Anne Arundel General Hospital Revell Highway Rt YES NO F 3. NAME OF First Middle Lost DATE Month Doy Year DECEASED (Type or print) John 19 67 Carroll SCOTT March 22 DEATH S SEX 6. COLOR OR RACE 8 DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 7 MARRIED **NEVER MARRIED** remove lost b rthdoy) Months Dovs Hours White WIDOWED 🔀 1881 Male DIVORCED April 5. and and in an 1Do JSUAL OCCUPATION (Give kind of work done 106 KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT COUNTRY? FURNITURE Maryland U. S. 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME. ar remayal, attending physoermit. Then f RGINIA PATRICK WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dates of service) crematian, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c),) -transit PART I. DEATH WAS CAUSED BY DASET AND DEATH IMMEDIATE CAUSE (6) 1001 DUE TO signed to burial-treburial, co Conditions, if any, which gove to rise to immediate cause (a), DUE TO stoting the underlying couse lost. 9 WAS AUTOPSY PART II. OTHER-SIGNIFICANT CONDITIONS CONDITIONS TO DEATH BUT NOT RELATED TO THE FERMINAL DISEASE CONDITION GIVEN IN PART 1(0) PERFORMED? NO 20b. DESCRIBE HOW INJURY OCCURRED (Enternation of injury in Port I or Port 11 of item 18) 2Do ACC DENT WAS UNDER YING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 2Dc TIME OF INJURY Month, Dov. Year 2Dd INJURY OCCURRED 2De PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour 'o.m. Not While foctory, street, office bldn., etc.) at work 21. I certify that (I) (this hospital) attended the deceased from 196 ) that (1) (we) last O FUNERAL DIRECTOR: saw the deceased alive an M from causes and an the date stated abave. and that death accurred at 22b DATE SIGNED 220. SIGNATURE **ATTENDING** MD. PHYS. 22c. PHYSICIAN'S 22d. ADDRESS director, pa should be f NAME (Type) St. MARGARETS FUNERAL DIRECTOR 2Sh. REGISTRAR S SIGNATURE VR A15 (4)



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03095 CERTIFICATE OF DEATH law requires that the death certificate be executed within 24 hours after death USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) PLACE OF DEATH o. COUNTY o. STATE b. COUNTY MARYLAND (I outside corporate limits, c. LENGTH OF STAY IN 1b (If outside corporate limits, write RURAL and give nearest town) e RURAL and give pegfest town) d STREET ADDRESS e. IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSLITUTION (If not in hospital, give street address) NO X NAME OF DATE Middle Year DECEASED OF DEATH (Type or print) S. SEX 6. COLOR 9. AGE (I vegrs IF UNDER 1 IF UNDER 24 HRS 7. MARRIED NEVER MARRIED rpfinave birthday) Months Doys Hours WIDOWED DIVORCED pub 100 USUAL OCCUPATION (Give kind of work done KIND OF BUSINESS 12 CHIZEN OF WHAT COUNTRY? 13. FATHER'S NAMI burial, cremation, ar remayal, 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO (Yes, ap, brunknown) (If yes give wor or dotes of service 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gave rise to immediate couse (o), DUE TO stating the underlying couse of Health prior to lost QS 19 WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) NO 200 ACCIDENT WAS UNDERLYING [ 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 1B) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20s. PLACE OF INJURY (Home, form, 20f (City or town) (County) (State) Hour o.m. foctory, street, office bldg., etc.) While Not While at work at work 19\_\_\_\_, that (I) (we) last 21. I certify that (I) (this haspital) attended the deceased fram. 19 \_\_\_. to\_ M, fram causes and on the date stated above. O FUNERAL DIRECTOR: saw the deceased alive and 19 and that death accurred at 22a SIGNATURE 22b. DATE SIGNED M D DIRECTOR director, page shauld be filed 22c PHYSICIAN Se NAME (Type) BURIAL, CREMATION 250 REC'D BY REG STRAR Marlen



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03096 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death I. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased fixed, if institution. Residence before admission) b. COUNTY Anne Arunel o. COUNTY Anne Arundel Maryland MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ve carbán papers. Pag event, within 72 hours 11 hrs. Annapolis Mayo d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) .⊑ d STREET ADDRESS 214 Maryland Ave., ON A FARM? Anne Arundel General Hospital Beverly Beach YES NO 3 NAME OF Middle DATE Month remove carban Lost Year DECEASED OF DEATH SHERZEY March 67 William Otto (Type or print) SEX 6 COLOR OR RACE IF JNDER 1 YEAR IF JNDER 24 HRS NEVER MARRIED B. DATE OF BIRTH AGE (In years 7. MARRIED lost birthdoy) Months Hours White Male WIDOWED DIVORCED Jan. 29. 1917 100 JSUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) .2 CITIZEN OF WHAT ar removal, and in during most of working life even if retired)
Retired Meat Cutter INDUSTRY COUNTRY? attending physician sermit. Then please Washington, D.C. U.S. 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME William B. Sherzey Emma Nordhorff 1S. WAS DECEASED EVER IN J.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service) 16. SOCIAL SECURITY NO 17 INFORMANT Address permit. Isabel A. Sherzey cremation, 18 CAUSE OF DEATH (Enter only one couse per lide for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o) NTERVAL BETWEE signed by the burial-transit purial, cremative by the hospital ar attending physician. Conditions, if ony, which gave rise to immediate couse (a), stating the underlying couse as the priar to PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT 40T RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? be detached far use State Dept. of Health YES TYTHE NO F certificate 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port 11 of item 18) 20o ACCIDENT WAS JNDERLYING . OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER (City or town) 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (County) (Stote) Hour o.m. Not While foctory, street, office bldg . etc.) ot work ot work TO FUNERAL DIRECTOR; After 21. I certify that (I) (this hospital) aftended the deceased from. director, page 3 shauld shauld be filed with the 196 ), and that death accurred of 1.10PM, from causes and on the date stoted obove saw the deceased olive on 220. SIGNATURE DIRECTOR M.D 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 1407 Forest Drive, Annapolis, Md. Peter F. Verkouw. M.D. 230 BURIAL CREMATION, 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) BREMOVAL (Specify) March 10.1967 Cedar Hill Cemetery Prince Georges. Maryland 250 REC'D BY REGISTRAR 24 FUNERAL DIRECTOR ADDRESS VR A15 (4) 25M 1/67 lheml Funeral Home, Suitland



| _ 1  | MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND   |
|--|--|
| FOR STATE  | 03097 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03087  |
| HEALTH DEPT.   | 1. PLACE OF DEATH  2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)  5. COUNTY  6. COUNTY  7. STATE  7. COUNTY  8. COUNTY  8. COUNTY  9. STATE  10. COUNTY  11. COUNTY  12. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)  |
| that be and  | Anne Arundel Maryland Maryland Arundel   |
| cessar<br>funera<br>may b<br>artmer<br>r death   | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |
| the fe   | Glen Burnie  d. Name of Hospital Or Institution (if not in hospital, give street address)  d. STREET ADDRESS  [e. IS RESIDENCE   |
|  | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  N. Arundel Hospital  ON IF FARM?  YES NO   |
| felay in 3 to nd 3 to Page State hours   | 3. NAME OF First Middle Last 4 BATE Month Day Year   |
| The The  | OF OF OTHER MARION KENT SHOCKLEY DEATH March 27 19 67  |
| 上二百 章章   | 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years   IFUNDER 1 YEAR   IFUNDER 24 HRS   |
| ath.   | Male White WIDOWED DIVORCED   Feb. 5,1920   47 yrs.  |
| er dea<br>ive Pa<br>with<br>  and<br>  event   | 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND DF BUSINESS OR during most of working life, even if retired) INDUSTRY  11. BIRTHPLACE (State or foreign country) COUNTRY?  |
| s afte<br>18. Gi<br>110ng<br>110ng<br>110ng<br>110ng   | Mechanic United Airlines   Fairland, Oklahoma USB  13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME  |
| m 18<br>e all<br>pag   | Thomas Shockley Bessie Mc Minn   |
| 24 ho<br>1 Hen<br>Office<br>File<br>and  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SDCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown)   (If yes gire war or dates of service)  |
| hin Sill ir<br>r's l   | Yes   WIII 548-26-2323 Mrs Eleanor S. Shockley (wife) Same as#   |
| EXAMINER: This certificate should be executed within 24 hours after death. If the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, should be forwarded to the Chief Medical Examiner's Office along with form files.  **Tollow The Chief Medical Examiner's Office along with form files.  **Tollow The Chief Medical Examiner's Office along within any event within designated agent, prior to burial, cremation, or removal, and in any event within the content of the  | 18. CAUSE OF DEATH [Enter only one cause pgr line for (a), (b), and (c).]  INTERVAL BETWEEN ONSET AND DEATH  |
| ecuted<br>ng" in<br>il Exa<br>il Exa<br>ransit<br>on, or   | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  An direction of the control of  |
| ild be execut<br>"pending"<br>f Medical<br>t burial-trans<br>cremation,  | Conditions, if eny, which it   |
| Med<br>Med<br>Med<br>ouria   | gave rise to immediate   |
| oulc<br>ord<br>hief<br>hief<br>al, c   | underlying cause lest. (c)   |
| ate shoul<br>he Word<br>he Chiel<br>ed as a<br>burial,   | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)  19. WAS AUTOPSY PERFORMED?   |
| iffication the the to the to the to the total to the tota | YES NO YE |
| certification ded to be brior  | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)  PERFORMED?  YES   19. WAS AUTO-SY PERFORMED?  YES   NO    PRIMARY   Or CONTRIBUTING    CAUSE OF DEATH.   |
| R: This crate, write forward should agent, pagent, pag |  |
| age age  | 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE DF INJURY (Home, farm, 20f. (City or town) (County)  Hour e.m. While at work at work at work at work  |
| the certificate should be not files. Tiles. CCOR: Page designated  | 21. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion   |
| EXA<br>in our files.   | death resulted from: Natural causes 👺 Accident 🔲, Suicide 🔲, Homicide 🔲, Undetermined manner 🔲   |
| 4 4 2 55   | ACTUAL CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER 22. DATE SIGNED   |
| Page or or or or   | SIGNATUR MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER A  |
| DEPUTY<br>ease ex<br>rector.<br>trained f<br>FUNERAL   | EXAMINER'S NAME (Type) L. LINGISK (JT. Address (Street, city, town, or county) 3/27/67   |
|  | 23a. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)   |
| 5  | Cremation March 29,1967 Loudon Park Crematory   Balto., Maryland  24. FUNERAL DIRECTOR ADDRESS   25a. REC'D BY REGISTRAR'S SIGNATURE   |
| VR ALSME (5)   | Richard V. Singleton Glen Burnie, Md. MAR 30 1967 Clearles Vision  |
| 5M 1/65  | Turnett o o lour   |



MARYLAND STATE DEPARTMENT OF HEALTH 03088 The law requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY o. STATE b. COUNTY Anne Arundel Maryland MARYLAND Anne Arundel b. CITY OR TOWN (If ourside corporate imits, write RURAL and give nearest tawn)

Annapolis C LENGTH OF STAY IN 16 c CITY OR TOWN (If autside corporate limits, write RURAL and give negrest town) physician and completely filled in by en please remave carbon papers. P Glen Burnie Rural carbon papers. d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Anne Arundel General Hospital YES I NO F Box 302A. Solley & Opal Rds. remaye carbon 3. NAME OF Middle Last 4 DATE Doy Year DECEASED (Type or print) Castell DEATH 19 67 Eleanor Simmons March S SEX 9 AGE ( n years IE UNDER 24 HRS. 6 COLOR OR RACE 7 MARRIED NEVER MARRIED B DATE OF BIRTH 1887 b rthdoy) Months Doys Hours W. DIVORCED WIDOWED 10a USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR | | BIRTHPLACE (County & State or fareign cauntry) 12 CITIZEN OF WHAT during most of working the even if retired) V NIDUSTRY COUNTRY'S . A. Beanscove, Pa. 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME Deniel Castael Merthe Donahue 17 INFORMANT IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO Address (Yes, no, ar yakpawn) (If yes give wor or dates of service) Unknown John 世. EMMXMM Simmons(husband) 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN burial-transit PART I, DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (a) signed by DHF TO Conditions, if any, which gave rise to immediate cause (a), **DUE TO** stating the underlying couse Page 4 may be retained by the hospital ar attending IO FUNERAL DIRECTOR: After this certificate has been as the WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) far use NO [ 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.) 20g. ACC DENT WAS UNDERLYING [ OR CONTRIBUTING I CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER! 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Manth, Doy, Year factory, street, office bldg., etc.) Not While 19 at work 21. 1 certify that (I) (this haspital) attended the deceased from Mar. 14, 1967, to Mar. 18, 1967, that (I) (we) last saw the deceased alive on Mar. 18, 1967, and that death accurred at 8:20M, from causes and on the date stated above 22a SIGNATURE 22b. DATE SIGNED STAFF PHYS.  $\boxtimes$ Mar. 20, 1967 M.D. director, page 3 shauld be filed a DIRECTOR 22d. ADDRESS 22c. PHYSICIAN S NAME (Type) Ray M. Smith Hahn Professional Bldg., Severna Pk., Md. 23d LOCATION (City or Tawn) 23c NAME OF CEMETERY OR CREMATORY 23a BURIAL, CREMATION, 23b. DATE THEREOF (County) (State) BUTTOVAL Specify) Brooklyn, Meryland 22Merch 1967 Ceder Hill Cemetery 25b. REGISTRAR'S SIGNATURE 25a, REC'D BY REGISTRAR VR A15 (4) 20 M 1/66 Milaneles Singleton Funeral Home/Glan Burnie.Md.





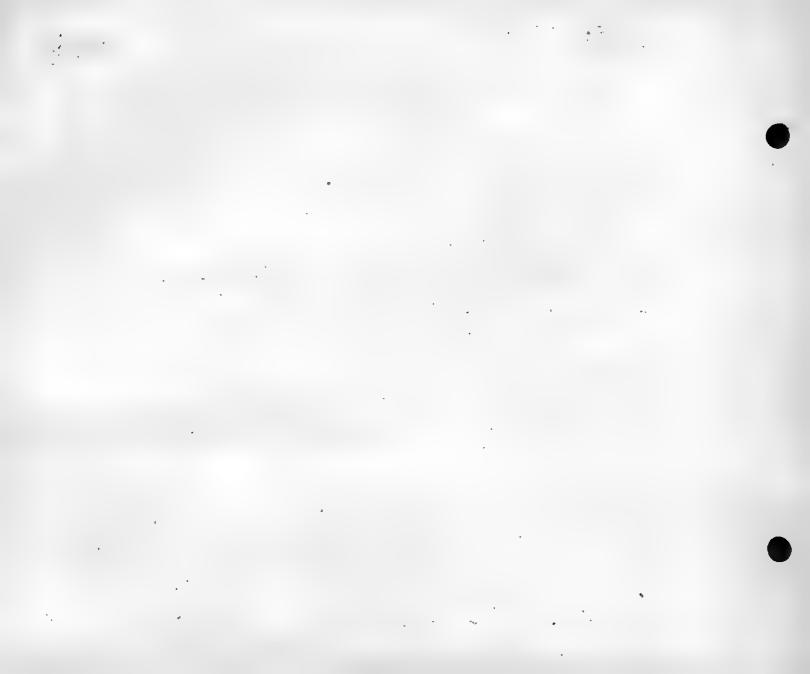
|               | 03100                                     |  |            | CERTIFIC                  | CATE       | OF DEAT                    | Н                 |                                      | 0309             |                                |
|---------------|---|--|------------|---------------------------|------------|----------------------------|-------------------|--------------------------------------|------------------|--------------------------------|
| 1.            | PLACE OF DEATH                            |  |            |                           | 2.         | USUAL RESIDEN              | CE (Where deco    | ased lived, If ins                   |                  | e before edmiss                |
| 1             | Anne Arun                                 |  |            | MARYLA                    | IND        | Maryl                      | and               | Anne A                               |                  |                                |
| }             | b. CITY OR TOWN (                         | f oulsida corporate limi                 | its,       | c. LENGTH OF STAY         | - 11       | c. CITY OR TOWN (I         |                   | nta limits, write R                  | URAL and giva r  | nearest lown)                  |
| _             |   | Meade, Kar                               |            | 10 day:                   |            | Pasade                     | na                |                                      |                  |                                |
|               |   |  |            | ital, give street eddress | )          | d. STREET ADDRESS          |                   |                                      |                  | IS RESIDEN     ON A FAR        |
|               |   | AH, Ft Geo                               |            |                           |            |                            | aron Dr           | ive                                  |                  | YES NO                         |
| 3.            | NAME OF<br>DECEASED                       | First                                    |            | Middle                    |            | Last                       | 4. DATE<br>OF     | Month                                | Dey              | Aeet                           |
|               | (Typa or print)                           | Edgar                                    |            | 0.                        |            | nith                       | DEATH             | March                                | 2                | 1967                           |
| _             | SEX                                       | _  | 7. MARRIED | NEVER MARRIED             |            | ATE OF BIRTH               | 9                 | AGE (In yeers IF<br>last birthday) A | Aonths Days      | Hours   Mil                    |
|               | ale                                       | Cau                                      | WIDOWED    |                           |            | ne 7, 1917                 | 49                | yrs.                                 |                  |                                |
| d             | one during most of wo                     | ON (Give kind of worl                    | id) [      | OF BUSINESS OR IN         |            | 1. BIRTHPLACE (Coun        |                   |                                      |                  | F WHAT COUN                    |
|               | etired US                                 | Army                                     | CIVI       | 1 Service                 |            | Baltimore,                 |                   | d                                    | USA              |                                |
|               |   | 4.1.                                     |            |                           |            | MOTHER'S MAIDEN            |                   |                                      |                  | *                              |
| _             | illiam Smi                                | .T.M<br>ER IN U.S. ARMED FOR             | OPAR Lad   | OCIAL SECURITY NO.        |            | gatha Leib                 |                   |                                      |                  |                                |
| Y             | es, no, or unkown) [[                     | fyesgive war or detest of s<br>.942–1960 | ervice)    |                           |            |                            | ar.               | Sharen I                             |                  |                                |
| 1             |   |  |            |                           | Made.      | leine Smith                | (W)Pasa           | dena, Ma                             |                  |                                |
|               |   | H WAS CAUSED BY:                         |            | te Pancreat:              | itie       |                            |                   |                                      |                  | ERVAL BETWEEN<br>SET AND DEATH |
|               |   | IMMEDIATE CAUSE (⊕)<br>∠                 |            | - Tancicao                | 1010       |                            |                   |                                      | -                | -                              |
|               | 0000                                      | 201.10                                   | Pvml       | ehlebitis                 |            |                            |                   |                                      | ]                | week                           |
|               | Canditions, if any<br>gave rise to immedi | ate ceuse                                |            | -                         |            |                            |                   |                                      | -                |                                |
|               | (e), steling the u                        | nderlying DUE TO                         |            |                           |            |                            |                   |                                      |                  |                                |
| ~             | ceusa fast.                               | SIGNIFICANT COND                         | TIONS CONT | TRIBUTING TO DEATH B      | LIT NOT D  | ATED TO THE TERMS          | IAL DISEASE CO    | MOITION CIVEN                        | LINI DADT 1(a) 1 | OTHE SAW D                     |
| OH.           | PARI II OTHER                             | SIGNIFICANT CONDI                        | HONS CON   | INCOMING TO DEATH B       | O NOI K    | LATED TO THE TERMIN        | INE DISENSE CO    | ANDITION GIVEN                       |                  | PERFORME                       |
| 3<br>2<br>3   | 20a. ACCIDENT W                           | AS UNDERLYING (1)                        | 201 000    | TRIBE HOW INJURY OC       | CHORES     |                            | Dat Las Dat III   | -1.1. 10.1                           | 1                | res to NO                      |
| CERTIFICATION | OR CONTRIBUTING                           | CAUSE OF DEATH                           | 20b. DESC  | TRIBE HOW INJUST OC       | CORRED. (I | utet ustnie of luffich tu  | ren I of ren II ( | or Hem 10./                          |                  |                                |
| _             | 20c. TIME OF INJU                         | <u> </u>                                 | nr 120d II | NJURY OCCURRED   20       | a PLACE    | OF INJURY (Home, ferm      | , ; 20f. (City o  | r town)                              | (County)         | [Stele                         |
| MEDICAL       | Hour a.m.                                 |  | While      | Not While                 |            | street, office bldg., etc. |                   | . 10411,                             | (0001117)        | (a.z.e                         |
| \$            | p.m.                                      | 19                                       | et work    | <u> </u>                  | , 22       | Enhance                    | 10677 . 0         | Manala                               | 10 0             | (1) ( )                        |
|               |   |  |            | ed the deceased t         |            |                            |                   |                                      |                  |                                |
|               | saw the deceas                            | ed alive on                              | ela r.c.n  | 19,67, and                | that dea   | in occurred at: 1          | OAM, from it      | ne causes and                        | ou me dan        | 22h DA                         |
|               | No. 1.                                    | d TAI N                                  | hans       | 21111                     |            | ATTENDING A                | AED.              | STAFF<br>PHYS.                       | 2 Marc           | 4 - 516                        |
|               | 22c, PHYSICIAN'S                          |  | LUU L      |                           | M.D.       | 22d. ADDRESS               | Incerox [         | 71131 [25]                           | M TIGIL O        | ** T/O!                        |
|               | NAME (Type)                               | HOWARD M.                                | TANNI      | NG, CPT, MC               | 3          | Kimbrough                  | Army H            | ospital,                             | Ft G.M           | . Meade                        |
| 2.3           | a. BURIAL, CREMATI                        | ON, 23b. DATE THE                        |            | 23c. NAME OF CEM          |            |                            |                   | ION (City, town                      |                  | (State)                        |
|               | REMOVAL (Specify)                         | 6 March                                  | _          | Lorraine                  |            |                            |                   | imore .                              |                  |                                |
|               | Burial                                    | 1 0 1001 011                             | 277        | 1 1 7 1 6 6 1 1 1         | - F2P      |                            | a wall V.         |                                      | 2 AA 6           |                                |
| 24            | FUNERAL DIRECTOR                          |  |            | ADDRESS                   |            |                            |                   | AR 25b REGIS                         |                  | UIC JAG                        |



| DIVISION   | OF STATISTICAL                                    |                          | ND RECORDS        |   | ESTON STI                      | REET, BALTIN                    | ORE 1, MAI       | RYLAN         |
|--|---|--------------------------|-------------------|---|--------------------------------|---------------------------------|------------------|---------------|
| USIUi  |   | CE                       | RIFICAL           |   | PA 111                         |                                 | <u>ีบ</u> ฮบูรู  | 12            |
| 1. PLACE OF DEATH<br>8. COUNTY                     |   |                          |                   | 2. USUAL RES                            | IDENCE (What                   | a deceased lived, If<br>b. COUI |                  | nce before    |
| h CITY OF TOWN G                                   | outsida corporale limils,                         | C/                       | MARYLAND          | RANCE                                   | land                           | dinn                            | - ILA            | 20            |
| write RURAL and                                    | giva nearast town)                                | 1.18                     | OF STAY IN 16     | c. CIT OK II                            | AM fit oniside                 | corporate limits, writ          | a KUKAL and giva | nearast       |
| d. NAME OF HOSPIT                                  | AL OR INSTITUTION (IF                             | not in hospital, give si | reet address      | d. STREET AD                            | DRESS                          |                                 | an.              | . <u>/</u>    |
| Dlan H   | 1 - 11  |                          | /-                | 1201 51                                 | /_/                            | 3.70                            | 1                | YES           |
| . NAME OF  | First   | 162002 P                 | Middla            | Last                                    | 4, DA                          | Me Mon                          | h Day            | 1 163         |
| DECEASED (Type or print)                           | ( break   | X/ AA J                  | · ·               | 5-11/                                   | OF<br>DEF                      | TH 🖻                            | . 20             | - 1           |
| 5. SEX   | 6. COLOR OR RACE 7                                | . MARRIED   NEVER        | MARRIED . 8.      | DATE OF BIRTH                           | !                              | 9. AGE (In years                | IF UNDER 1 YEAR  |               |
| R/1/e  |   | WIDOWED 🕢 1              | DIVORCED   5      | 7-23-                                   | 1896                           | lest birthday)                  | Months Days      | Hour          |
| 10a. USUAL OCCUPATION dona during most of work     | ON (Give kind of work king life, even if retired) | 10b. KIND OF BUSH        | INESS OR INDUSTRY | 11. BIRTHPLACE                          | (County & State                | , or foreign country            | 12. CITIZEN      | OF WHA        |
| BAIL RO  | Ad.   |                          |                   | Milare                                  | Wand.                          | ,                               | 4.5              | · A           |
| 13. FATHER'S NAME                                  |   |                          |                   | 14. MOTHER'S A                          | AIDEN NAME                     |                                 | -                |               |
| AVA/hA   | yiel S  | milh                     |                   | MAR                                     | 1A Me                          | AL.                             | a 0.150          |               |
| 15. WAS DECEASED EVE<br>(Yas, no. oriunkown)   (If | k IN U.S. ARMED FORCE<br>yesgiya warordalas ofsan | vica) 16. SOCIAL SEC     | 1 7               | 4 .                                     | , 1                            | Addres                          | ANNAL            | 1021          |
| 18. CHUSE OF DE                                    | EATH [Enter only one ca                           | UNEDO                    |                   | ORINA_                                  | HAWKI                          | 142-148                         | OWEST.           | S/<br>ITERVAL |
| PART I. DEATH                                      | WAS CAUSED BY:                                    |                          | 11                | 1                                       |                                |                                 |                  | NSET A        |
|  | MMEDIATE CAUSE (a)                                | O COX                    | end Cal           | elucara                                 | 2                              |                                 | 3/2              | oric.         |
| Conditions, if any,                                | which ) (b)                                       | AN Paris                 | P. The            | #                                       | 12                             | 12 -                            | and the second   | 1/2           |
| gave risa to immadia                               | io couse  | 1) -                     | >                 | Charly                                  | LC C P. A                      | aca                             | Carry M. La.     |               |
| (a), stating the un causa last.                    | (c)   | Limited                  | 21                |   |                                |                                 |                  |               |
| Z PART II. OTHER                                   | SIGNIFICANT CONDITION                             | ONS CONTRIBUTING         | TO DEATH BUT NOT  | RELATED TO THE                          | TERMINAL DISEA                 | SE CONDITION GI                 | VEN IN PART 1(a) | 19. WA        |
| [ [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [            |   |                          |                   |   |                                |                                 |                  | YES [         |
| PART II. OTHER OF CONTRIBUTING I                   | CAUSE OF DEATH                                    | 206. DESCRIBE HOW        | INJURY OCCURRED   | . (Entar nature of i                    | njury in Part I or             | Part II of item 18.)            |                  |               |
|  | MEDICAL EXAMINER)                                 |                          |                   |   |                                | (a)                             |                  |               |
| 20c. TIME OF INJUR<br>Hour a.m.                    | Y Month, Day, Year                                | WhileNot Wi              | ······            | CE OF INJURY (Horry, street, office blo | na, farm, † 201.<br>lg., etc.) | (City or fown)                  | (County)         |               |
|  | 19  | al work at wo            |                   | 1 17                                    | 1                              |                                 |                  |               |
|  | at (I) (this hospital                             |                          |                   |   |                                |                                 |                  |               |
| saw the decease                                    | ed alive on22                                     | <i>≯</i>                 | and that o        | death occurred                          | al/.e/M, ft                    | om the causes                   | and on the da    | ste stat      |
| Michian  | 11/11.41  | chut                     | J.M               | ATTENDING                               | MED.                           | STAFF PHYS.                     | 7                |               |
| 22c. PHYSICIAN'S                                   | 7   | 13111                    | M.L               | 22d. ADDRES                             |                                | /1/2                            | 55/              |               |
| NAME (Type)  | Chora   | 14.17u                   | 1111              | 102 C                                   | urull                          | my flew                         | A Ke zu          | ch            |
| 238. BURIAL, CREMATIC                              | ON, 236. DATE THERE                               | OF 23c, NAM              | ME OF CEMETERY O  | R CREMATORY                             | 23d. L                         | OCATION (City, to               | wa or county)    |               |
| BURIAL   | 13-29-  |                          |                   | 144                                     |                                | NAPOLI                          |                  | 11/10         |
| 24 FUNERAL DIRECTOR                                | S SIGNATURE                                       | ADD                      | RESS              | 25                                      | A REC'D BY RE                  | GISTRAR 25b PE                  | GISTRARIO SIGNA  | TURE          |
| C, C, 1  | 7/2/15 -  | 11- A1                   | NAPO.             | 415, mad                                | 4AR 3 1                        | 1301                            | 0                | 0             |



| 8 (14)   |               | DIVISION OF STATISTICAL RESEARCH AND RECORDS, 30 CERTIFICATE   | 11 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |
|--|---------------|--|--|
| \$ \@\#  | _             |  | OF DEATH 03093   |
| funeral<br>1 and X<br>r death.   | 1.            | PLACE OF DEATH a. COUNTY 2.  |  |
| ter<br>he i<br>fter  |               | Anne Arundel MARYLAND  | a. STATE b. COUNTY Anne Arundel  |
| s af<br>by t<br>age<br>rs ar   |               | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  c. LENGTH OF STAY IN 1b                              | CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |
| in Source  | _             | Glen Burnie  | Pasadena 02-1  |
| 24 hours after filled in by the papers. Pages 1  |               |  | STREET ADDRESS   0. IS RESIDENCE   DN A FARM?  |
|  | <u> </u>      | North Arundel Hospital   | Route 4, Box 59 YES NO T   |
| executed within and completely remote chept in any event, within any event, within   | 3.            | DECEASED   | Last 4. DATE Month Day Year  |
| de d   | 5.            | (Type or print) Mary Smi   | th DEATH 3 24 1967 DATE OF BIRTH 19. AGE (In years   IFUNDER 1 YEAR IIF UNDER 24 HRS.  |
| scut<br>note<br>ny e   |               | WILDDING THE BURDOCK TO  | last birthday)   Months   Days   Hours   Min.  |
|  | 10:           |  | .25-96 70 yrs.   |
| be<br>icial  | du            |  | CDUNTRY?   |
| ohys   | 13            | Housewife Lune   | Germany US . MOTHER'S MAIDEN NAME  |
| rtific<br>ng p<br>Then<br>mov  |               | Unhamm   | 1126   |
| cell t   | 15            | S. WAS DECEASED EVER IN U.S. ARMED FORCES?   16. SDCIAL SECURITY ND.   17. INFO  | DRMANT Address   |
| atta<br>arta<br>on, o  | ["            | es, no, or unkown) (If yes give war or dates of service) No 220-36-9607 Pat  | ient" a chart " Head Rice (-   |
| e de<br>the<br>t pe  | -             | 18. CAUSE DF DEATH (Enter only one cause per line for (a), (b), and (c).]  | I INTERVAL BETWEEN   |
| requires that the death certificate be execuding physician. been signed by the attending physician and the burial-fransit permit. Then please remote to burial, cremation, or removal, and in any  |               | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock   | DNSET AND DEATH  |
| tha<br>sicis   |               | 15 6 × DUE TD /  |  |
| phy<br>phy<br>buri   |               | Conditions, if any, which ) the Ventorual Ca   | "cumotos   |
| equi<br>ling<br>seen<br>the<br>to  |               | gave rise to immediate cause (a), stating the DUE TD   |  |
| rw r<br>tend<br>as t<br>as 1   | Z             | underlying cause last. (c)   | MIG  |
| rath that  | E             |  | TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?  |
| al o al o lea un | FIC           | Or lincher Has Harris Harris Charles   | LOUS CUFEOSE YES NO [  |
| D HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be Page 4 may be retained by the hospital or attending physician.  D FUNERAL DIRECTOR: After this certificate has been signed by the attending physician director, page 3 should be detached for use as the burial-transit permit. Then please should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in the state Dept.  | CERTIFICATION | 20a. ACCIDENT WAS UNDERLYING   20b. DESCRIBE HOW INJURY OCCURRED OR CONTRIBUTING   CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | D. (Enter nature of injury in Part I or Part II of Item 18.)   |
| IYS)<br>e hc<br>his tach<br>tach   |               |  | F INJURY (Home, farm, 20f. (City or town) (County) (State)   |
| oy the   | MEDICAL       |  | treet, affice bldg., etc.)   |
| tibin<br>Affi<br>Id b  | 2             | 21.   certify that (I) (his hospital) attended the deceased from Man   | ch 23 1967 to March 24, 1967, that (1) (we) last   |
| TEN<br>tain<br>108:  |               | Asaw the deceased dive on Mass 27 1967, and that dea   | ath occurred at 5 35 M, from the causes and on the date stated above.  |
| R A1   |               | 22a. VSIGIUTURE  | 22b. DATE SIGNED   |
| DE D   |               | 1.15. (aure M.D. P   | ATTENDING MED. MED. STAFF 3/24/67  |
| O HOSPITA<br>Page 4 ms<br>O Funeral<br>director, p   |               | PANAME (Type) F. B. RAMIREZ  | 22d. ADDRESS 3527 ANNAPOLIS RTY BACK 27  |
| HOS<br>Ige -<br>FUNI<br>Pectal   | 238           |  |  |
| 15 Page 75 Pag | 200           | a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR C   | talaca (State)   |
| P  | 24            |  | 25a. REC'D BY REGISTRAR   25b. REGISTRAR'S SIGNATURE   |
| VR AJ5 (4)   |               | Tobet S. Barrences Severna Ri  | MAR 27 1007 Ocharles Inder   |
| 2DM 1/65   | 1             | Property S 121-DODICO  | Charles of the state of the sta |



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W, PRESTON STREET, BALTIMORE, MARYLAND 21201 03103 MEDICAL EXAMINER'S CERTIFICATE OF DEATH HEALTH DEPT. I. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence o COUNTAnne Arundel b. COUNTINA Arundel o. STAWarvland tronsit permit. File pages land 2 with the State Department of event within 72 hours after death. MARYLAND b CITY OR TOWN (If outside corporate imits, c LENGTH OF STAY IN 16 c (ITY OR TOWN (if outside corporate - mits, write RURAL and give nearest town)
Pasadena 5 hours d NAME OF HOSPITAL OR NSTITUTION (If not in hospital, give street oddress)

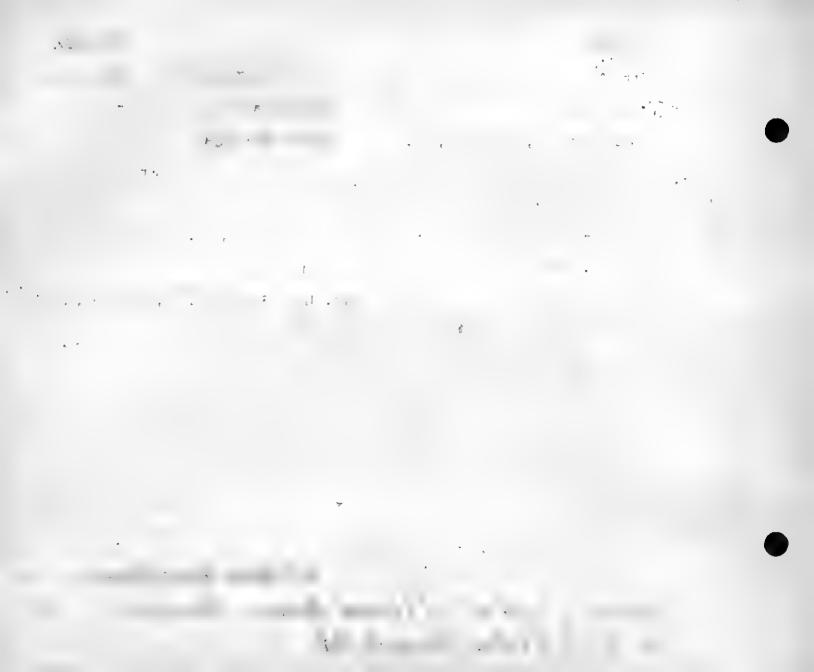
A.A.Cty Cent.Hqtrs.Police Station

Millersville d. STREET ADDRESS e IS RESIDENCE should be forworded to the Chief Medical Examiner's Office along with form ON A FARM? Rt 5, Box 82, Carroll Rd. NO 125 NAME OF First 4 DATE Sparkman, Jr. March DECEASED Melvin (Type or print) DEATH S SEX 6 COLOR OR RACE 8. DATE OF BIRTH AGE (In years IF UNDER 1 YEAR 7 MARRIED NEVER MARRIED birthdov) Months Hours 2/14/26 DIVORCED WIDOWED 1Db KIND OF BUSINESS OR 11 B.RTHPLACE (Stote or foreign country) 12 CIT ZEN DE WHAT 100 USLAL OCCUPATION (Give kind of work done during most of working life eyen if retired) be executed within 24 14 MOTHER'S MAIDEN NAME 13 FATHER'S NAME WAS DECEASED EYER IN U.S. ARMED FORCES? 17 INFORMAN (Yes, no, or unknown) (If yes give worker doles of service DATE OF DEATH (Enter only one couse per line for (a) (b), and (c) PART I. DEATH WAS CAUSED BY. NTERVAL BETWEEN ONSET AND DEATH Hanging IMMEDIATE CAUSE (o) writing the word DUE TO in ony Conditions, if ony, which gove (b) nse to immediate cause (o), DUF TO stoting the underlying couse or removol, PART II OTHER'S GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY PERFORMED? YES 4 NO 2Do EXTERNAL CAUSE WAS PRIMARY- OF CONTRIBUTING 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of inury in Port I or Port II of item 18) 3 should Hung himself with his belt CAUSE OF DEATH 20c T ME OF NJLRY Month, Doy Year 2Dd NJURY OCCURRED 20e PLACE OF INJURY (Home form 2Df (City or fewn) (County) (Stote) foctory street office bldg etc.)

11 block Not While 5 moy be retoined for your O FUNERAL DIRECTOR: Poge 67 of work O of While Cell Millersville.A.A. Md. 21 I certify that I took charge of the remains described above, held on Autopsy [2] Inspection . Inquity ..., ond in my opinion geoth resulted from Noturos couses Su cide 3 Homicide . Undetermined monner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER Heolth prior SIGNATURE March 19,1967 Werner U. DEPUTY MEDICAL EXAMINER Spitz **EXAMINER'S** NAME (Type) Address (Street, city, town, or county) 23c NAME OF CENTURY OR 23b. DATE THEREOF 230 BURNAL CREMATION AD DRESS 2So REC'D BY REGISTRAR VR A15ME (5) 6M 1/67



| 1  | MARYL DIVISION OF STATISTICAL RESEAR   |  | ARTMENT OF HEALTH<br>301 W. Preston Street, Ba                   | LTIMORE 1, MARYLAND  |
|--|--|--|--|--|
| 4 204<br>4   | 03104  | CERTIFICATE                            |  | 03095  |
| death.<br>uneral<br>and 2<br>death.  | 1. PLACE OF DEATH a, CDUNTY  |  |  | red, If institution: Residence before admission)                             |
| after after  | Anne Arundel   | MARYLAND                               | a. STATE MARYLAND  | b. COUNTY ANNE ARGINDEL  |
| 13 a 8 8 8   | write RURAL and give nearest town)   |  |  | limits, write RURAL and give nearest town)                                   |
| hour<br>s. lin<br>hou  | Annapolis d. NAME OF HOSPITAL OR INSTITUTION (if not in hospi                              | l day                                  | PASADENA  d. STREET ADDRESS                                      | e. IS RESIDENCE  |
| 24 hv<br>filled<br>sapers<br>in 72 l   | Naval Hospital, Annapolis,   |  | RT10 Box 8GC   | ON A FARM?   |
|  | 3. NAME OF First   | Middle                                 | Last 4. DATE   | YES NO W   |
| uted within completely ove carbon event, with  | (Type or print) Baby Girl  | ······································ | SPEAS DEATH  | March 22 19 67   |
| executed with and complete remove carlingage event,  | 5. SEX 6. CDLDR DR RACE 7. MARRIED   | NEVER MARRIED 3 8.                     | DATE OF BIRTH 9. AGE (   | In years IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Irthday) Months Days Hours Min. |
| executed con remove over the contract of the c | Female Cauc. WIDOWED   |  | 21 March 196/  | yrs.   |
| physician of please r  | 10a. USUAL DCCUPATION (Give kind of workdone during most of working life, even if retired) | STRY STRY                              | 11. BIRTHPLACE (County & State, or forei                         | CDUNTRY?   |
| ate be<br>hysicii<br>pleas<br>ni, and  | 13. FATHER'S NAME  |  | Annapolis, Md.  14. MOTHER'S MAIDEN NAME                         | USA  |
| certifica<br>Iding ph<br>Then<br>remova  | William H. SPEAS   |  | Irene KOC  |  |
| eath certifí<br>attending p<br>ermit. Then<br>on, or remov   | 15. WAS DECEASED EVER IN U.S. ARMED FDRCES?   16. SDC                                      | HALSECURITYND.   17. II                | NEDRMANT   | Address  |
| e death c<br>the atten<br>it permit.<br>nation, or a   | (Yes, no, or unknown) (If yes give war or dates of service)                                | Mrs                                    | (Mother) . Irene Speas, Rt. 1                                    | 0, Box 86-C, Pasadena,   |
| at the deat<br>ian.<br>d by the at<br>transit pern<br>cremation,   | 18. CAUSE OF DEATH [Enter only one cause per line  | for (a), (b), and (c). )               | • •  | INTERVAL BETWEEN<br>ONSET AND DEATH  |
| at the san the | PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)   | remarks                                | rah .  |  |
| uires that the or physician a signed by the burial-transit by burial-transit by the burial cremating the company of the company of the burial, cremating the company of the | Conditions, If any, which \ (b)  |  |  | 32 hours   |
| require<br>ding pl<br>been s<br>the bu<br>or to bu   | gave rise to immediate (   |  |  |  |
| aw requi   | underlying cause last. (c)   |  |  |  |
| 一型 至 <i>年 、</i> 计  | PART II. OTHER SIGN IF ICANT CONDITIONS CONTRIBUTION                                       | IG TO DEATH BUT NOT RELATE             | ED TO THE TERMINAL DISEASE CONDITION                             | GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?                                |
|  | 20a. ACCIDENT WAS UNDERLYING TO 20b. DESC  | anios day miliny nagun                 | DED CELLS OF LEGISLAND   | YES ND   |
| ATTENDING PHYSICIAM: The retained by the hospital or a CTOR. After this certificate i should be detached for use with the State Dept. of Health  | DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                        | CRIBE HOW INJURY DCCURI                | RED. (Enter nature of Injury in Part I or                        | Part II of Item 18.)   |
| PHY<br>the<br>deta<br>deta   | Hour a.m. 19 at work   | RY DCCURRED 20e. PLACE factory         | OF INJURY (Home, farm, 20f. (City or street, office bidg., etc.) | town) (County) (State)   |
| DING P<br>od by t<br>After<br>d be d<br>e State  |  | at work                                |  |  |
| TAL OR ATTENDI<br>may be retained<br>AL DIRECTOR: A<br>page 3 should<br>e filed with the   | 21. I certify that (I) (this hospital) attended to   |  | leath occurred atM, from the                                     | causes and on the date stated above.   |
| ATT rets   | 22a. SIGNATURA   | = 139, and that t                      |  | 22b. DATE SIGNED   |
| y be DIR age   | Ch Dandre  | M.D.                                   | PHYS. MED. STA   | 経口コンラターに一  |
| 출수 없 일급 /  | 22c. PHYSICIAN'S NAME (Type)   |  | U.S. NAVAL HOSP  | T. AUNTROLIS MB  |
| O HOS<br>Page<br>D FUN<br>direct   | 23a. BURIAL, CREMATION, 23b. DATE THEREOF 2:   | 3c. NAME OF CEMETERY D                 | IR CHEMATORY 23d. COCATION                                       | (City, town or county) (State)   |
| BE   | 13 (LP) 13 - LY - UNERAL DIRECTOR/   | ADDRESS                                | HEADEMY HIS AVI  | 20061S PID.  |
| VR AI5 (4)   | I.b. M - to to or som ( )  | wand m                                 | MAR 2 7 1967   | Icharles Judge   |
| 20 M 1/65  | Jan 17 Salan 12 Cons   | 1000                                   | T I DATE: W T 1001   | " 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1                                      |



MARYLAND STATE DEPARTMENT OF HEALTH



MARYCAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03106 CERTIFICATE OF DEATH and campletely filled in by the funeral remave carban papers. Pages 1 and 2requires that the death certificate be executed within 24 haurs after death. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. STATE o. COUNTY b. COUNTY Anne Arundel MARYLAND Maryland Anne Arundel c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate I mits, write RURAL and give nearest tawn) 417 Joyce Drive Millersville vears d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS S RESIDENCE ON A FARM? YES NOWES Knollwood Manor Nursing Home Glen Burnie. Md. 3 NAME OF 4 DATE Dov Year DECEASED 19 67 STANSBURY March 5. Lillian Rumpf (Type or pnnt) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS S SEX 6 COLOR OR RACE 8 DATE OF BIRTH 9. AGE (In years 7 MARRIED **NEVER MARRIED** birthdoy Months Days 1894 WIDOWED Sept 1. Female Cauc. DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY please the attending physician sit permit Then please S. Ba. MMXXXXXX Nursino 14 MOTHER'S MAIDEN NAME 13 FATHER'S NAME Carolyn (unknown) Karl Rumof 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT Address 16 SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give wor or dotes of service) 219 16 1914 Carolyn Carter - Same as # No 18 CAUSE OF DEATH (Enter only one cause per line for (o), (b) and (c)) INTERVAL BETWEEN signed by the burnal-transit p m SNET AND DEATH PART I DEATH WAS CAUSED BY IMMEDIATE (AUSE (a) Respratory insufficiency Pulmonary emphysema and fibrosis many year: Conditions, if onv. which gove rise to immediate couse (a). DUE TO stating the underlying couse Bronchitis acute & chronic, and bronchiectasis O FUNERAL DIRECTOR: After this certificate has been director, page 3 should be detached far use as the TY WAS AUTOPSY PERFORMED? detached far use YES T NO TY OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year foctory, street, office bldg, etc.) Not While at work ot work 21. I certify that (I) (this haspital) attended the deceased from June 30 , 1965, toMarch 5, 1967, that (I) (we) lost TO HOSPITAL ON PROBLEM Page 4 may be retained by Page 4 may be retained by Page 4 may be retained by African Page 4 may be retained by Page 4 may be saw the deceased alive an March 3 1967, and that death accurred at 4 : 00M, fram causes and an the date stated above 22b. DATE SIGNED 22a, SIGNATURE ATTENDING XIX STAFF PHYS. March 5, DIRECTOR M.D South River Medical Edgewater, Maryland 22d. ADDRESS 22c. PHYSICIAN S Charles W. Kinzer, M. D. NAME (Type) directar, shauld be 23c NAME OF CEMETERY OR CREMATORY
Baldwin Memorial Ch Cem. Millersville, 230 BURIAL, CREMATION, 23b DATE THEREOF (Stote) REMOVALT Specify) 3/8/1967 256 REGISTRAR'S SIGNATURE ADDRESS 2So REC'D BY REGISTRAR 24. FUNERAL DIRECTOR 1967 Singleton Funeral Home/Glem Burnie. Md.



| 1  |                 | DIVISION OF VIT   | MARYLAND STATE DEPA   | ARTMENT OF HEALTH<br>ON STREET, BALTIMORE, MARYLAND 212                     | 201   |
|--|-----------------|---|---|---|---|
| FOR STATE  |                 | 1. <b>1.1</b> 1.17  | ,   | CERTIFICATE OF DEATH  | 03098   |
| HEATTH DEPT.   | 1               | PLACE OF DEATH O. COUNTY ANNE ARUNDE  | MARYLAND  | 2 USUAL RESIDENCE (Where deceased lived if in o. STATE Maryland b.          | stitution Residence before admission) COUNTY ANNE ARUNDEL |
| f any delay min PM3 Parment  |                 | b (ITY OR TOWN (if autside carparate imits<br>write RURAL and give nearest tawn)<br>Annapolis     | ← LENGTH OF STAY IN 16  | c CITY OR TOWN (flautside carparate imits, write Annapolis                  | 21  |
| - K & / e / .  |                 | Apartment Americana   | ANDRAPT 107   | 10 STONNORMAN DR HONDOC STREET A  | PT. 107 PES NO IN A FARM?  YES NO IN                      |
| Page With  |                 | NAME OF First DECEASED (Type or print) FLORENCI   |   | DER   | arch 31, 1967   |
|  |                 | SEX 6 COLOR OR RACE 7 MAR Female White WIDO   | OWED DIVORCED U   |   | y) Manths Doys Haurs Min                                  |
|  | du              | ing prost of working te, eyen if retured)   | OB KIND OF BUS NESS OR INDUSTRY                                       | 11 BIRTHPLACE (Stole or foreign country) HALIFAX PENN                       | 12 CIT ZEN OF WHAT COUNTRY A.                             |
| within<br>in pencil<br>Examinel<br>File page<br>2 baurs a  | 13              | FATHERS NAME THEODORE ETTE  | ER  | MARY BRUBAK   | ER  |
| be executed within<br>"pending" in pencil<br>lief Medical Examine<br>insit permit, File pag<br>ent within 72 haurs o   | 15<br>(Y        | WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war ar dates af service)                     | MR  | INFORMANT<br>5. JAMES R. HOLST SE   | TUES RD.  |
|  |                 | 18 CAUSE OF DEATH (Enter only one cause per<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (o) | ne far (a), (b), and (c)) Asphyxia                                    |   | NTERVAL BETWEEN<br>ONSET AND DEATH                        |
| e shauld be the ward "pe ta the Chief to the Chief iburial-transit in any event  |                 | Gandstans, fany, which gave (b) (b) (b)   | Carbon Monox  | ide   |   |
| ificate<br>ting th<br>rided to<br>as a b<br>and in   |                 | stating the underlying cause   DUE TO    ast   (c)  | Conflagratio  |   |   |
| This certificate shauld cate, writing the ward be farwarded ta the Clebe used as a burial-tremaval, and in any ev  | CATION          |   |   | THE TERM NA. DISEASE COND TON GIVEN IN PART 1(6                             | YES NO Z  |
| INER: The certificate shauld be files. 3 shauld to shauld to the shauld  | . CERTIFICATION | PRIMARYAL OF CONTRIBUTING C   | Found in burnin   | (Enter nature of in vry in Port I or Port II of item 18                     |   |
| KAM<br>te th<br>le 4<br>/aur<br>age<br>emal  | MED CA.         | Hou XXX   | 20d INJURY OCCURRED 1 20e PLAC<br>While Nat While at work 1 of wark 1 | CE OF INJURY (Hame, farm only, street, office bldg , etc.)  house Annapolis | Anne Arundel Md.  |
| A1 execution of the property o |                 | 21 <b>I certify</b> that I took charge of the death resulted fram Natural cause                   | e remains described above, he<br>es D. Accident 🛣, Suic               | ide, Homicide, Undetermine  | Inquiry, and n my apinia<br>d manner                      |
|  |                 | ACTUAL SIGNATURE Charles J.   | degat   | CH EF MEDICAL EXAMINER X  MD ASS STANT MEDICAL EXAMINER X                   | 22 DATE SIGNED  |
| F F SS C F 7   | 00              | EXAMINER'S Charles S. Spi   | ringate, M.D.   | DEPUTY MEDICA, EXAMINER  Address (Street, city, town, or county)            | March 31, 1967  |
| TO D<br>nece<br>the<br>5 m   | 23              | BEMOVAL (Specify)  FUNERAL DIRECTOR   | 7 WHITEMARSH  |   | 1, Montgomerko, E.  |
| VR A15ME (5)<br>6M 1/67  | L.              | ONN M. TAYLOR SONS  | ANNABUS NI  | DATE PR 3 1967  | Acharles Judge  |

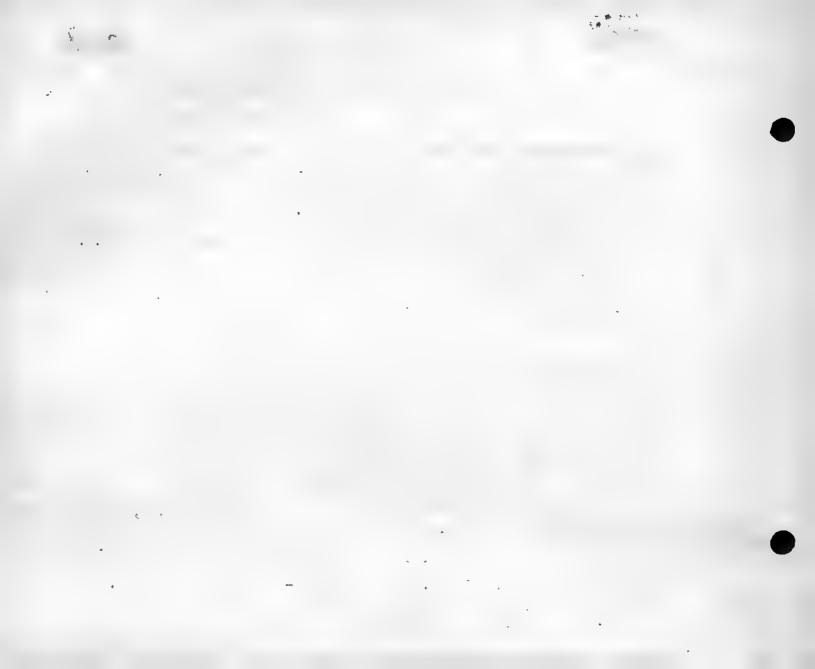
 $I = \frac{\pi}{2} \cdot \epsilon$ 

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

|  |               | 03108 CERTIFICATE OF DEATH 03099   |
|--|---------------|--|
| after death<br>he funeral<br>ges 1 and 2<br>after death  |               | PLACE OF DEATH REWARD COUNTY HOSPIE AGE COUNTY MARYLAND 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) b. COUNTY Charles  |
| Z T P S S S  |               | b (ITY OR TOWN (If outside corporate limits write RURAL and give nearest town)  c. LENGTH OF STAY IN 1b  c (ITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Bryantown  |
|  |               | d NAME OF HOSPITAL OR INSTITUTION (If not in hospita, give street address)  CROWNSVICLE ST. HOSPIEC CROWN SVILLE - MD BRESIDENCE ON A FARM?  YES NO []   |
| be executed within and campletely fill pe remaye carban po in any eventament.                    | 3             | NAME OF DECEASED   A DATE   Month   Day Year   DECEASED   OF DEATH   3   1967  SEX   16 COLOR OR RACE   7 MARRIED   NEVER MARRIED   8 DATE OF BIRTH   9. AGE (n years   IF UNDER 1 YEAR   IF UNDER 24 HRS)   |
| and cam<br>remaye  | L             | SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 8 DATE OF BIRTH 9. AGE (n years let UNDER 1 YEAR 11 UNDER 24 Hrs. Manths Days Hours Min. WIDOWED DIVORCED 2 - 8 - 19 16 Jost brinday) yes USUA, OCC. PATION (Give kind of work done 10b KIND OF BUSINESS OR 11, BIRTHPLACE (County & State, or fareign country) 12. CITIZEN OF WHAT  |
|  | dur           | rather's Name  The country?  |
| the death certificate<br>ne attending physician<br>t permit Then pleas<br>stran, ar removal, and |               | ACBERT. D. SWERTNET LORREY SWEETNEY. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT   |
| he death cei<br>attending p<br>permit The<br>ian, ar remo  |               | s, na, ar unknawn) (If yes give war ar dates af service) Los oph Sweetney-Bryantown, Md.  18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  INTERVAL BETWEEN  |
| that<br>an.<br>by the<br>ransi   |               | PART I DEATH WAS CAUSE (a) Hy PRA TENSIVE FAILURE Propos. ONSET AND DEATH  ONSET AND DEATH  ONSET AND DEATH  ONSET AND DEATH   |
| requires<br>physici<br>n signed<br>e burial-l<br>a burial,                                       |               | Canditions, if any, which gave trise to immediate cause (a), stating the underlying cause DUE TO   |
| he law<br>intendini<br>nas beer<br>e as the<br>priar t   | NC            | PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  19 WAS AUTOPSY PERFORMED?   |
| CIAN: Topical or efficate by far us af Health  | CERTIFICATION | YES . NO   |
| G PHYSIC<br>the haspit<br>this certification<br>detached<br>to Dept. af                          | MEDICAL (     | (IF EITHER, NOTIFY MEDICAL EXAMINER)  20c TIME OF INJURY Manth, Day, Year Hour a.m.  P.m. 19 at wark a |
| ATTENDING etained by th CTOR: After th shauld be de rith the State                               |               | 21. I certify that (I) (this haspital) attended the deceased fram 123/61, 19, ta 3/6/67, 19, that (I) (we) lass saw the deceased alive on 1/6/7, 19, and that death occurred at 1/6/2, M, from causes and on the date stated above   |
| = m =  |               | 22a SIGNATURE  M.D. ATTENDING MED DIRECTOR STAFF  22b. DATE SIGNED  3 / 12 / 12 / 12 / 12 / 12 / 12 / 12 / 1   |
| O HOSPITAL OR Page 4 may be of Funeral Director, page 3 should be filed                          |               | NAME (Type) L. BENEDICT M) Committee State Magnitude   |
| TO HOSP<br>Page 4 r<br>To FUNER<br>director,   | Z             | BURIAL CREMATION, 23b DATE THEREOF 23c, NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (State), REMOVAL (Specify) 3-16-67 St. Marys Ch. Cemetery Discharge Chair Md.  ADDRESS J 250, REGISTRAR 2018 TOWN Chair Md.   |
| VR A15 (4)<br>20 M 1/66  | 1             | Martell adams aguas co, Md. DAMAR 20 1967  |

in the state of th

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03109 CERTIFICATE OF DEATH death Ifter death, campletely filled in by the funeral ave carban papers. Pages Land 2. USUAL RESIDENCE (Where deceosed lived, if institution. Residence before admission) 1. PLACE OF DEATH b. COUNTY Anne Arundel p. COUNTY a. STATE Anne Arundel Maryland cuted within 24 haurs after MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn) ve carban papers. Pag event, within 72 haurs Severna Park 4 days Annanolis d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress) d. STREET ADDRESS e. IS RESIDENCE 514 Evergreen Road Anne Arundel General Hospital YES T NO IS 3. NAME OF Middle please remave carban First Lost 4. DATE Month Year DECEASED TASSEY 67 Ellen March Barbara 19 (Type or print) DEATH S. SEX 6 COLOR OR RACE B. DATE OF BIRTH 9. AGE (In veors IF UNDER 1 YEAR IF UNDER 24 HRS. 7. MARRIED NEVER MARRIED last\_birthaoy) Months Dovs Hours Female White WIDOWED Sept. 4, 1911 and in any DIVORCED law requires that the death certificate bear 100 JSUAL OCCUPATION (G ye kind of work done 10b KIND OF BUSINESS OR 12 CIT ZEN DE WHAT 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if satired COUNTRY? the attending physician sit permit. Then please Massachusett Schoo 13 FATHER'S NAME 14-MOTHER'S MAIDEN NAME ar remaval, 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17a-INFORMANT (Yes, no, Ar unknown) (If yes give wor or dotes of service) crematian. INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH (Enter only one couse per line-for (o), (b), and (c). burial-transit PART I. DEATH WAS CAUSED BY. signed by MMEDIATE CAUSE (o) Page 4 may be retained by the haspital or attending physician. DUE TO Conditions if ony, which gove rise to immediate couse (a). DUE TO far use as the t stoting the underlying couse this certificate has been PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) WAS AUTOPS PERFORMED? State Dept. of Health NO 200 ACCIDENT WAS UNDERLYING [ 205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port 1) of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) factory, street, office bldg., etc.) Hour o.m Not While ot work TO FUNERAL DIRECTOR: After , to Mar. 2. , 19 67 that (1) (w a) last 21 Learnity that (1) (this charming) attended the deceased from . 19 director, page 3 should should be filed with the 19.67, and that death occurred at 3.8 M, fram causes and on the date stated above sow the deceased alive on March 2 220. SIGNATURE 22b. DATE SIGNED ATTENDING PHYS. PHYS. \* M D. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Box-73, Severaa Park, Robert R. 23c. NAME OF CEMETERY OR CREMATORY 230 BURIAL, CREMATION. 23b. DAVE THEREO! 23d. LOCATION (City or Town) REMOVAL (Specify) 25b. REGISTRAR'S SIGNATURE 250, REC'D BY REDISTRAR VR A15 (4) 20 M 1/66 MAR 6 DATE



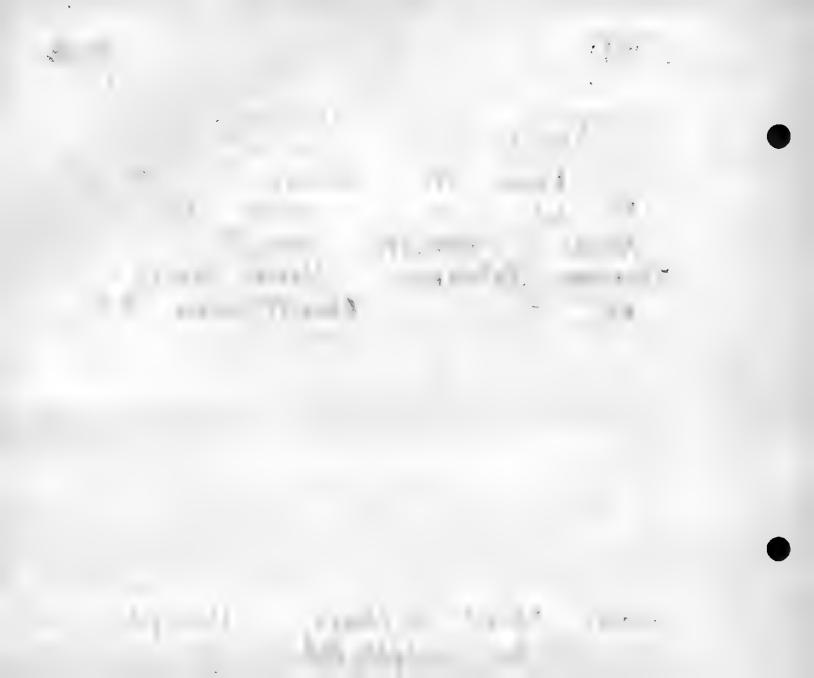
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03110 CERTIFICATE OF DEATH nours after death 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) PLACE OF DEATH g. COUNTY a. STATE MARYLAND outside corporate limits. **ELENGTH OF STAY IN 15** autside carparate l'mits, write RURAL and give negrest town) neorest town) filled in by d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d STREET ADDRESS IS RESIDENCE ON A FARM? in ony event, within 72 RSING YES NO 🕟 requires that the death certificate be executed within Middle NAME OF DATE Manth Oav Year corbon completily DECEASED 0F 19 (Type or print) DEATH 5 SEX 6 COLOR OR RACE MARRIED NEVER MARRIED геточе Ust-bythday) Hours Manths Days OIVORCED WICOWEO 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT 10g USUAL OCCUPATION (Give kind of work done during host of working life, even if retired) Cat FATHER'S NAME MOTHER'S MAIDEN NAME or remov WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. INFORMANI (Yes, no or unknown) (If yes give war ar dates of service STEELE ANE ANERP. cremotion, CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) I-tronsit PART 1. OFATH WAS CAUSED BY IMMEDIATE CAUSE (a) ò DUE TO signed buriol-tr Conditions, if any, which gave (b) rise to immediate cause (a). QUE TO stating the underlying cause the has been Health prior to lost S WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) CATION NO certificate 6 20b OESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port II of item 18.) 20g ACC DENT WAS UNDERLYING [ OR CONTRIBUTING CAUSE OF GEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, form, (Gty or town) (County) (State) 20c TIME OF INJURY Month, Oay, Year Haur 10.m. factory, street, affice bldg , etc.) Nat While ot wark 21. I certify that (I) (this hospital) attended the deceased from be retained and that death accurred a cost M, from causes and an the date stated above saw the deceased alive an O FUNERAL DIRECTOR: 220. SIGNATURE 22b DATE **ATTENOING OIRECTOR** M.O. PHYS. director, page should be filed 22c. PHYSICIAN'S 22d. ADDRESS O HOSPITAL NAME (Type) OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION, (County) FUNERAL DIRECTOR 25b



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03111 CERTIFICATE OF DEATH by the funeral Pages 1 and 2 nours after, death? requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) o. COUNTY MARYLAND campletely filled in by the fundave carban papers. Pages 1 Anne Arundel b CITY OR TOWN (If outside corporate limits, c LENGTH OF STAY IN 1b c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) Baltimore d. NAME OF HOSP TAL OR INSTITUTION (If not in hospitol, give street oddress) 27 days d. STREET ADDRESS e IS RESIDENCE ON A FARM? 216 Bridgeview Rd. Crownsville State Hospital YES NO X 3. NAME OF Middle 4. DATE Month Doy Year (Type or print) #34560 and in any event, Johnson Tellington DEATH 19 67 Theresa SEX IF UNDER 1 YEAR IF UNDER 24 HRS 8. DATE OF BIRTH AGE (In years 6 COLOR OR RACE 7. MARRIED **NEVER MARRIED** remave last birthdoy) Months Doys Hours 4-25-24 Female Negro WIDOWED DIVORCED guq 10o USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 1) BIRTHPLACE (County & Stole, or foreign country) 12. CITIZEN OF WHAT COUNTRY? USA during most of working life, even if retired)
Housewife ease INDUSTRY Whitmire, S.C. ed by the attending physici al-transit permit. Then ple al, crematian, or remaval, a 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME Joe H. Johnson Estelle Epps 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17 INFORMANT Address (Yes, no, or unknown) ((If yes give wor or dotes of service) Hospital Records 3-20-7325 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH Pneumonia. Acute Renal Failure PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) attending physician. signed b burial-tr burial, a DUE TO Malignent Hypertension? Conditions, if any, which gove nse to immediate couse (a), DUE TO stating the underlying couse **D FUNERAL DIRECTOR:** After this certificate has been directar, page 3 shauld be detached far use as the should be filed with the State Dept. af Health priar ta 19 WAS AUTOPSY PART IF OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) PERFORMED? CERTIFICATION Psychosis, Extreme Obesity YES | NO [ Manic - Denressive 205. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) TIME OF INJURY Month, Dov. Year factory, street, office bldg., etc.) Not While , 19 67 , to , 19<u>67</u>, that (I) (we) last 2). I certify that (I) (this hospital) attended the deceased fram 2/8/ ond that death occurred aR: 15 M, from causes and on the date stated above. sow the deceosed olive on, 22n. SIGNATURE 22b. DATE SIGNED X 3/7/67 M.D. PHYS. DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN S NAME (Type) Benedict. Crownsville State Hospital. Md/ 23b. DATE THEREOF 23d. LOCATION (City or Town) 23c NAME OF CEMETERY OR CREMATORY 23o BURIAL, CREMATION (County) (Stote) BUY Specify) Laurel 3-11-67 Carver Mem 2Sb. REGISTRAR'S SIGNATURE 250 REC'D BY REGISTRAR 24. FUNERAL DIRECTOR DAMAR Morton & Dvett F. H. 1701 taurens St

745 - 75-\_ ' 1 ξ

| 1  | DIVISION OF V   | MAKTLAND STATE DEPA<br>ITAL RECORDS, 301 W. PRESTOT |  | YLAND 21201  |
|--|---|---|--|--|
| = (A-1)  | 03112   | CERTIFICATE   | OF DEATH   | 03103  |
| funeral<br>Tond  | 1. PLACE OF DEATH a. COUNTY   | MARYLAND  | 2 USUAL RESIDENCE (Where deceded o. STATE              | sed lived, if institution Residents before admission) b. COUNTY              |
| 24 haurs after death ed in by the funeral ppers. Pages 1 and 172 hours after death   | b. CDY OR TOWN (If autiside corporate limits, write RURAL and give nativest town)   | c. LENGTH OF STAY IN 16                             | CATY OR TOWN (If autside corpora                       | te limits, write RURAL and give nearest town)                                |
| lled in papers.  | d NAME OF HOSPITUL OR INSTITUTION (If not in h  | iaspital, give street address)                      | 430 2 ND   | 57.    O IS RES DENCE ON A FARM? YES   NO X                                  |
| equires that the death certificate be executed within 24 haurs after physician. signed by the attending physician and completely filled in by the fur burial-transit permit. Then please remove, carbon papers. Pages 1 burial, crematian, ar removal, and in any event.   | 3. NAME OF DECEASED (Type or pnnt)  | M. Middle TH  | OMAS 4. DATE OF DEATH                                  | Month Day Year 7   |
| execute<br>d comp<br>move, c   | F W W   | ARRIED NEVER MARRIED 8.  NOWED DIVORCED 7           | DATE OF BIRTH 1-14-1901                                | AGE (In years IF JNDER   YEAR IF UNDER 24 HRS Months Days Hours Min          |
| ote be com an com an and in com and in com   | 10a USUAL OCCUPATION (Give kind of work dane<br>during most of working life, even if retired)   | 106 KIND OF BUSINESS OR INDUSTRY                    | PHILA, Pa  | reign country) 12. CITIZEN OF WHAT COUNTRY? 4.5.                             |
| certifice<br>g physi<br>fhen pl<br>moval,  | TRUEMAN BOT   | SSEAW   | MARIE H  | EALEY  |
| death<br>iffendín<br>ermit.<br>n, ar re  | 15 WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war ar dates of servi                                      | ice)  | DNA M. Bow   |  |
| hat the n. yy the cansit p   | 18 CAUSE OF DEATH (Enter only one cause per<br>PART 1. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a)  | r line for (a) (b), and (c)) College Careine        | oma famere   | INTERVAL BETWEEN ONSET AND DEATH   |
| hysicia<br>hysicia<br>igned b<br>urral-tr<br>urral, cr   | Canditions, if ony, which gave (b)  | Metostatie 1  | adeno Casimo   | ma Jemphitodes Useknow   |
| law rading been to the far to  | stoting the underlying cause lost.  |   | ·  |  |
| N: The ar atte has truse a saith pr  | PART II OTHER SIGNIFICANT CONDITIONS CONTRI  20g ACCIDENT WAS UNDERLYING  OR CONTRIBUTING CLOSE OF DEATH OF EITHER MOTIFY MEDICAL EXAMINERS |   |  | PERFORMED? YES NO  |
| YSICIAI<br>ospita:<br>certifice<br>hed fa:   |   | 205. DESCRIBE HOW INJURY OCCURRED. (I               |  |  |
| NG PH y the h y the this e detac   | 20x TIME OF INBURY Month, Doy, Yeor Hour, o'm 19  | While Not While of work of work of work             | E OF INJURY (Home, form, y, street, office bldg, etc.) | (City or town) (County) (State)  |
| TTENDI<br>amed b<br>OR: Af-<br>nauld b   | 21. I certify that (I) (this hospital) saw the deceased alive an 3 22a. SIGNATURE   | attended the deceased from 1967, and that           |  | a 3-16, 1967, that (1) (we) la<br>A, fram causes and an the date stated abov |
| L OR A<br>L be rett<br>DIRECT<br>DIRECT<br>Segre 3 sk<br>filed with  | 22c PHYSICIAN'S   | phene MD  | ATTENDING MED DIRECTOR  22d. ADDRESS                   | PHYS 3-17-67   |
| TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Page 4 may be retained by the hospital ar attending physician.  TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled director, page 3 shauld be detached for use as the burial-transit permit. Then please remove, carbon poshauld be filed with the State Dept. at Health priar ta burial, crematian, ar removal, and in any event, within | NAME (Type) WIT 7 STE   | PHENS  23c. NAME OF CEMETERY OR C                   | 38 Comhill   | CATION (Cry of Town) (County) (State)  |
|  | BREMAN ACTU 3-20-6  | 7 St. MARY  | 2Sa. REC'D 8Y REGISTI                                  | UNA POLIS MD.  |
| VR A15 (4)<br>2SM 1767   | John M. Jay Int Alus  | amapolis, Y   | nd. MAR 21 K   | 67 Schooles Judge  |



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 03113 death. requires that the death certificate be executed within 24 hours after death signed by the attending physician and campletely filled in by the funeral burial-transit permit. Then please remave carban papers. Pages 1 and burial, crematian, ar remaval, and thank event, within 72 haurs after deather 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission, PLACE OF OEATH a. COUNTY a. STATE b. COUNTY Anne Arundel MARYLAND Marvland b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Raltimore d STREET ADDRESS Crownsville 3 Davs d NAME OF HOSP TAL OR INSTITUTION (If not in hospital, give street address) e IS RESIDENCE ON A FARM? NO X 1028 Pennsylvania Ave YES [ Crownsville State Hospital 3 NAME OF Last 4. OATE Day Year DECEASED OF DEATH (Type or print) #34926 Howard IF UNDER 1 YEAR Thomas 19 67 Lee IF UNDER 24 HRS 5 SEX 6. COLOR OR RACE 7 MARRIED 8 DATE OF BIRTH 9. AGE (In years NEVER MARRIED lost birthday) Manths Days Haurs WIOOWEO OIVORCED 2/19/35 Negro 12. CITIZEN OF WHAT IDo JSUAL OCCUPATION (Give kind of work done 1Db KIND OF BUSINESS OR 1) BIRTHPLACE (County & State or fareign country) COUNTRY? during most of working life, even if retired) INDUSTRY Howard Co. Maryland USA 14. MOTHER'S MAIDEN NAME 13 FATHER S NAME Thornton George Thomas 15. WAS DECEASED EVER IN U.S ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give war at dates of service) Hospital Records 18. CAUSE OF OEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE (AUSE (6) Acute Alcoholic Intoxication . Delirium Tremens Page 4 may be retained by the haspital ar attending physician. DUE TO Canditians, if ony, which gove (b) Pulmonary Edema. Severe Fatty Metamorphosis of Liver rise to immediate couse (a), OUE TO stating the underlying cause has been PART H OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPS)
PERFORMED? YES X NO F O FUNERAL DIRECTOR: After this certificate director, page 3 shauld be detached for us should be filed with the State Dept. af Healt Chronic Alcoholism PHYSICIAN: 2Do ACCIDENT WAS UNDERLYING [ 20b, DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Part II of item 18.) OR CONTRIBUTING CAUSE OF CEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (State) 20c TIME OF INJURY Month, Oay, Year 2De PLACE OF INJURY (Harne, farm, (City or town) (County) \_\_\_\_\_Bour\_cm Not While factory, street, affice bldg, etc.) at work ot wark 3/20 , 19 67, that (1) (we) last , 19 67 , ta\_ 21. I certify that (I) (this haspital) attended the deceased fram, 3/17/ 1967, and that death accurred at 9:30 M, fram causes and an the date stated above saw the deceased alive on\_ 22b. DATE SIGNED 22o, SIGNATURE  $\nabla$ 3/20/67 M.O. OIRECTOR PHYS. 22c PHYSICIAN'S Crownsville State Hospital, Maryland NAME (Type) Benedict, M.D. 23d LOCATION (City or Town)
A A County 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY (County) 23o. BURIAL, CREMATION (State) Cemetry DOTAL Specify) Censo RECD BY REGISTRAR 25b REGISTRAR'S SIGNATURE Ocharles VR A15 (4) Adolphus Halstead 1206 W North Ave 1967 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03114 CERTIFICATE OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before odm.ssion) a. COUNTY o. STATE b. COUNTY Anne Arundel MARYLAND Maryland Anne Arundel b CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c CITY OR TOWN (If gutside carparate limits, write RURAL and give negrest town) The law requires that the death certificate be executed within 24 hours of write RURAL and give nearest tawn) 8 hrs. 10 minRURAL -Annapolis Annapolis d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS ON A FARM YES NO Anne Arundel General Hospital Box 52 NAME OF Middle Last DATE Manth Day Year Completely DECEASED 12 1967 Edwin Moore TUCKER DEATH March (Type or pant) IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 9 AGE (In years 7 MARRIED **NEVER MARRIED** 8. DATE OF BIRTH last berthday) Months Hours Days March 2,1904 WIDOWED DIVORCED Male White 9 10a USUAL OCCUPATION (Give kind of work done IDb. KIND OF BUSINESS OR 12 CITIZEN OF WHAT BIRTHPLACE (County & State, or foreign country) and in COUNTRY? Maryland U. S. 13. FATHER'S NAME MOTHER'S MAIDEN NAME cremation, or removal, attending phys 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If we give war at dates of service 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) INTERVAL BETWEEN -tronsit PART I DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (o) signed by DUE TO Conditions, if any, which gave (b) rise to immediate cause (o). DUE TO stating the underlying cause be detached for use as the State Dept. of Health prior to lost PART H. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPS)
PERFORMED? NO certificote 2Dg ACCIDENT WAS UNDERLYING [3] 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part II of Item 18) by the nospital OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 2De. PLACE OF INJURY (Hame, form. (City or tawn) (County) (State) Hour a.m. factory, street, affice bldg, etc.) 2! I certify that (1) (this insight attended the deceased from 1/4) 1967, and that death occurred of\_ fram causes and on the date stated above. sow the deceased glive during 22b DATE SIGNED 22a. SIGNATURE DIRECTOR PHYS M.D. 22d ADDRESS O FUNERAL Gene D. Trettin, M.D. 98 Cathedral St. . Annapolis. director, shauld VR A15 (4) 25M 1/67



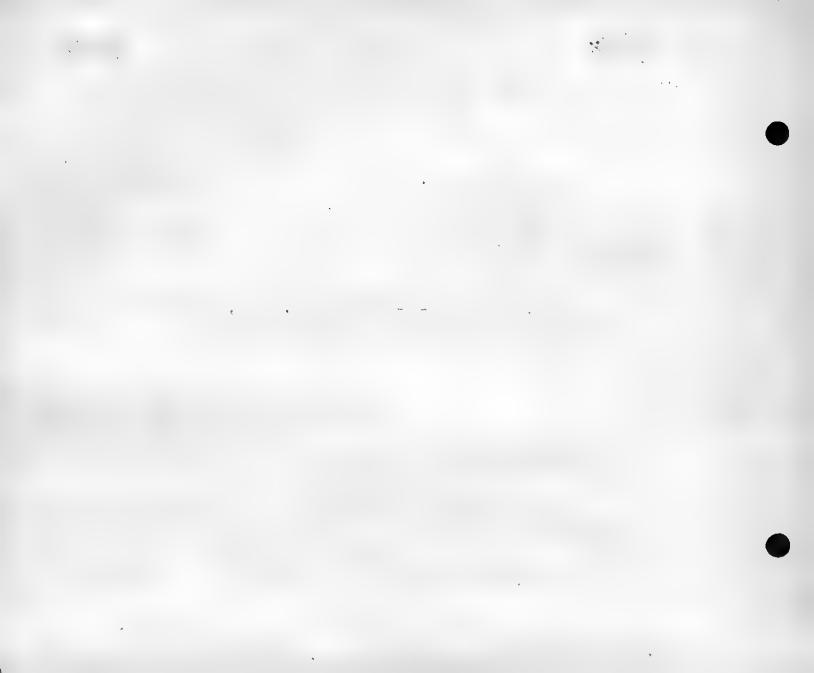
| , "  |   | MARYLAND STATE DEPARTMENT OF HEALTH ARCH AND RECORDS, 301 W. PRESTON STREET, BALTI          | MADE MADVIAND 21201  |
|--|---|---|--|
| -f-  | 03115   | CERTIFICATE OF DEATH  | MORE, MARTLAND 21201   |
| r death.   |   |   | ed lived, if institution. Residence before points on)                              |
| s after deat<br>the funeral<br>ages, Pund<br>ages, Pund  | 1. PLACE OF DEATH O COMMINE Armidel Sty   | MARYLAND MARYLAND MARYLAND C. LENGTH OF STAY IN 1b C. CITY ORTOWN Iff outside corpora       | Anne Armelel   |
| hours after by the fu  | b. CITY OR TOWN (If autside corporate limits,  Merite RURAL and gave nearest town)          | ? Annapolicio   | te limits, write RURAL and give nearest town)                                      |
| n 24 ho  | NAME OF HOSPITAL OR INSTITUTION (If not in hospitar,  | give street oddress) d STREET ADDRESS   | Annapolis e is residence<br>ON A FARM?<br>YES NO IT                                |
| ecuted within 24 ho<br>campletely filled in<br>ave carban papers.<br>y event, within 724 h   | 3 NAME OF DECEASED (Type or print) EDWARD   | A. Middle TURNER OF DEATH   | Month Doy Year  3 /3 1967  |
| xecuted<br>cample<br>nave con  | 5. SEX 6. COLOR OR RACE 7 MARRIED WIDOWED   | NEVER MARRIED 8. DATE OF BIRTH  | AGE (In yeors IF UNDER I YEAR IF UNDER 24 HRS dost burthday) Manths Doys Hours Min |
| e be ex<br>ign and<br>ase rem  | 100. USUAL OCCUPATION (G ve kind of work done during most of working life, every firetired) | KIND OF BUSINESS OR  11. BIRTHPLACE (County & State, or for MOLSTRY  LES Man-Ubbhaue Harles |  |
| ertificate be<br>physkian o<br>ten please<br>toval, and ir   | 13. FATHERS NAME Schward A Turner   | 14 MOTHER'S MAIDEN NAME   | rison  |
| at the death cer<br>the attending p<br>nsit permit. The  |   | SOCIAL SECURITY NO. 17 INFORMANT<br>12-01-2849 A Mus Mildred Turne                          | Address Cooke.   |
| the date of the cattern of the catte | 18 CAUSE OF DEATH (Enter on y one couse per lage for  | /   | INTERVAL BETWEEN GNSET AND DEATH   |
| that<br>an.<br>by th<br>fransi   | PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO                                       | reated Small Stokes   | I I I I I I I I I I I I I I I I I I I  |
| physician.<br>physician.<br>signed by<br>burial-tran   | Conditions, if ony, which gove ) (b)  | ere Jeneralized and brain Hr  | 1. Scles. C.V. Dis. 2 years  |
| ding Feen s the b  | storing the underlying couse (c) Out  | estion of ferminal molignam   | etastases.   |
| The law ratending attending has been se as the th priar to   | PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING   | TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVE                             | PERFORMED?   |
| Page 4 may be retained by the haspital ar attending physician.  To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4 may be retained by the haspital ar attending physician.  To FUNIRAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remave carban papers. Pages, Pand, shauld be filled with the State Dept. af Health priar to burial, crematian, or removal, and in any event, within 24 haurs affer a shauld be filled with the State Dept.  | ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH  | ESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port                       |  |
| PHYS he has this cel etache Dept.  | 20c. TIME OF INJURY Month, Doy, Year Hour o.m. While  | INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. foctory, street, office bidg., etc.) | (City or town) (County) (State)  |
| DING<br>  by the<br>  be d<br>  State  | p.m. 19 of wor  | nded the deceased fram 12-26, 1966, to  |  |
| OR ATTENDING be retained by the State of a shauld be ded with the State  | sgw) the deceased alive an 3/15/  |   | , from causes and an the date stated abave.  |
| OR A be ret be ret on 3 sie 3 sie ed wii   | Patr / Verkocu  | M.D. ATTENDING DIRECTOR   | STAFF 0 3/13/67  |
| O HOSPITAL O<br>Poge 4 may be<br>Puniral Dii<br>director, poge<br>shauld be filec  | 22C. PHYSICIAN'S NAME (Type) PETER TVERKO   | 407 Forest  | Onve Annapitis   |
| O HOSPITAL Page 4 may O FUNIRAL directar, pag shauld be fi   | 23g BURIAL (FREMATION, 23b DATE THEREOF 3-15-67   | 23c NAME OF CEMETERY OR CREMATORY HILLCREST HU  | CATION (City or Town)  Appolis  A, H, MD.  |
| VR A15 (4)   | 24 FUNERA DIRECTOR John M Tay by Son  | ADDRESS 250. RECD BY REGISTR  |  |



| -               | ~ 1   |   | Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 |   |                           |                 |                        |                  |                                      |                       |                                 |   |                            |
|-----------------|---|---|--|---|---------------------------|-----------------|------------------------|------------------|--------------------------------------|-----------------------|---------------------------------|---|----------------------------|
| 8               | EUD C   | TATE  |  | 03116   |                           |                 | L EXAMINER             |                  |                                      |                       | , MAKTLANI                      | 1 2 1 2 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | nty                        |
| <del>/-</del> - | HEALTH  | DEDT /  |  |   |                           |                 | - Excession            |                  |                                      |                       |                                 | 091                                     | U4                         |
|                 |   | (= 4)   |  | PLACE OF DEATH  o COUNTY  A.A. C                                      | e) -                      |                 | MARYLAND               | 0 51             | AL RESIDENCE (WHATE                  |                       | d, if institution R<br>b COUNTY | AACU                                    |                            |
|                 | y detay is<br>ond 3 to<br>PM3 Page  | portmen<br>after des  |  | b. CITY OR TOWN (if outside co  | rporote mits,<br>st town) | ( )             | ENGTH OF STAY N 16     |                  | OR TOWN (If auts                     | .4                    | orte RURAL a                    | nd give nearest t                       | awn)                       |
|                 | 1:00  | ofa   |  | MAME OF HOSPITAL OR INSTI   | JUTION (If not in ho      | spitol, give st | reet address)          | d STRE           | ET ADDRESS                           | - // //-              |                                 | 0                                       | IS RES DENCE<br>ON A FARM? |
|                 | th If ges I, form   | ote Deportme<br>hours after a   |  | D.O.A-Non14   | . PRUNG                   |                 | Hosp.                  |                  | 16 DOC,                              |                       |                                 | YE                                      | ON A FARM?                 |
|                 | r deot<br>ve Po<br>3 with   | the SI<br>n 72  | . 3  | NAME OF<br>DECEASED<br>(Type or print)                                | Jase Wh                   | ,               | Middle                 |                  | ldvon                                | 4 DATE<br>OF<br>DEATH | Month                           | Doy                                     | Year<br>19 67              |
|                 | 24 haurs ofter deoth if in Item 18 Give Pages 1, is Office along with form                  | with  | S  | SEX 6 COLOR   |                           | ARRIED Z        | NEVER MARRIED DIVORCED | B. DATE O        | 1 B - 14                             | 9 AGE I               |                                 | nths Doys                               | FUNDER 24 HRS<br>Hours Min |
|                 | haur<br>Item<br>Office  | lond2   | 10 du  | JSUAL OCCUPATION (Give kind of ing most of working life, even if r    |                           |                 | BUSINESS OR            | 31 Bil           | RTHPLACE (State of                   | foreign country)      |                                 | 12 CITIZEN OF V                         |                            |
|                 | 24<br>In<br>er's  | any (   |  | Teacher FATHER'S NAME   |                           |                 |                        |                  | iladelr<br>THERS MAIDEN NÃ           |                       | enna.                           | <u>U</u> S                              | . A.                       |
|                 | nould be executed within 24 word "pending" in pencil in 1 the Chief Medical Examiner's      | 3   | 1,3  |   |                           |                 |                        |                  |                                      |                       |                                 |   |                            |
|                 | Fxo Fxo   | (बह   | 15   | James Wald  | TOD                       | T 16 SOCIAL     | SECUR TY NO            | 17 INFORMAN      | {Donne                               |                       | Address                         |   |                            |
|                 | ol Tee  |   | (Y   | WAS DECEASED EVER NUS AR?<br>s, no, or unknown) (If yes give to       | wor or dotes of service   | e)              |                        |                  |                                      | _                     |                                 |   |                            |
|                 | oe execute<br>'pending''<br>ief Medico  | регг  |  | NO.   | agle and source nor       | 1182-           | 24-1999                | Faye             | Waldro                               | on 1                  | 46 Doc                          |   | Tive                       |
|                 | e e<br>pen  | r re  |  | 18 CAUSE OF DEATH (Enter<br>PART I. DEATH WAS CAU                     | SED BA-                   | ne ioi (o), (t  | o) ond (q.)            | DUNG F           | >                                    |                       |                                 |   | AND DEATH                  |
|                 | 문문  | tror'   |  | 322.0 IMME  | DIATE CAUSE (o)<br>DUE TO |                 | 7/7/                   | 17////           | /                                    |                       |                                 | 0                                       |                            |
|                 | wo  | <u> </u>  |  | Conditions, If any which gove   | 8 ) (6)                   | Acut            | e alcohol              | lic int          | toxicati                             | on                    |                                 | hea                                     | eden                       |
|                 | e sh<br>the<br>to   | emc   |  | rise to immediate couse (o) stating the underlying coust              | DUE TO                    |                 |                        |                  |                                      |                       |                                 |   |                            |
|                 | icot<br>ng<br>ded   | 0 S 0   |  | lost  | (c)                       |                 |                        |                  |                                      |                       |                                 |   |                            |
|                 | certificate should<br>writing the word<br>prworded to the Ch                                | used as a bunal-transit permit.<br>burial, cremation, or removal,                 | _  | PART II OTHER SIGNIFICANT C   | ONDITIONS CONTRIB.        | LTING TO DEA    | ATH BUT NOT RELATED    | TO THE TERMIN    | NAL DISEASE CONDI                    | TION G VEN IN PA      | ART 1(o)                        | 19 W                                    | AS AUTOPSY<br>REORMED?     |
|                 | is ce<br>e, v   |   | ISI  |   |                           |                 |                        |                  |                                      |                       |                                 | YES                                     | NO NO                      |
|                 | INER. This certificate should be certificate, writing the word should be forwarded to the C | rior rio  | CERT F CATION  | 200 EXTERNAL CAUSE WAS<br>PRIMARY ☐ or CONTRIBUTING<br>CAUSE OF DEATH |                           | 20b DESCRIBE    | HOW INJURY OCCUR       | tED (Enter notu  | ure of injury in Po                  | rt or Port 11 of 1    | tern 18 )                       |   |                            |
|                 |   | a short   | MEDICAL  | 20c TIME OF INJURY Month,   | Doy, Year                 | 20d INJURY      | OCCURRED 20e           | PLACE OF INJU    | JRY (Home, form,                     | 20f (City o           | or town)                        | (County)                                | (Stote)                    |
|                 | M. CAL EXAMINER:<br>pleose execute the certi  | oge<br>age  | 1 SE   | Hour om.  | 19                        | While of work   | Not While of work      | foctory, street, | office bldg , etc }                  |                       |                                 |   |                            |
|                 | L EXA<br>recufe<br>Page   | red Poy   |  | 21   Certify that 1 t   | aak charge of th          | ne remains      |                        | held an Ar       | itonsy 📝                             | Inspection [-         | Pourry                          | - and ir                                | my on high                 |
|                 | exe   | in Indian   |  | death resulted from   |                           |                 |                        |                  | Hamicide [                           |                       |                                 |   | , my op man                |
|                 | ose<br>rect   | REC<br>desi   | П  |   | 1                         | 4               | based I                | ,                | CHIEF MEDICAL EX                     |                       |                                 |   |                            |
|                 | Per P   | retained far y<br>L DIRECTOR: Po<br>its designated                                |  | ACTUAL SIGNATURE  | true head                 | 4.              |                        | M.D              | ASSISTANT MED CA                     |                       |                                 | 22.                                     | DATE SIGNED                |
|                 | o DEPUTY<br>necessary, p<br>the funeral   | 5 may be retained for your TO FUNERAL DIRECTOR: Page Health or its designated age |  | EXAMINER'S<br>NAME (Type)   | F. Liwh                   | ardi            | J.                     |                  | DEPUTY MEDICAL<br>Address (Street, o |                       | ty)                             | 3/_                                     | 3/67                       |
|                 | o Di  | E 2 E   | 23   | BURIAL, CREMATION, 2  | 3h DATE THEREOF           |                 | NAME OF CEMETERY       | OR CREMATOR      | Υ                                    | 23d. LOCATION         | (City or Town)                  | (County)                                | (Stote)                    |
|                 | <u> </u>  | 12  | I  | REMOVAL (Specify)   | /6/1967                   | Du              | r Lady c               | f The            | Fields                               | Mill                  | ersvil                          | le. Md                                  |                            |
|                 | 1/0   | ATEME (E)   | 2  | FUNERAL DIRECTOR  |                           |                 | ADDRESS                |                  | 2So RECD E                           | BY REGISTRAR          | 2Sb REGISTE                     | APS S GNATURE                           | Quelas                     |
|                 | ¥ R .   | A15ME (5)<br>M 1/66   |  | Raymond C.  | Fink G                    | len B           | urnie, M               | ld.              | DATE N                               | IAR 7                 | 1967 /                          | Cherre Car                              | 1                          |



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03117 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o COUNTY o. STATE **b.** COUNTY nd completely filled in by the fur emove corbon papers. Pages 1 gay event, within 72 hours after ANNE ARUNDEL MARYLAND MARYLAND HOWARD b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lawn) C LENGTH OF STAY IN 16 CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELLICOTT CITY FT GEO G MEADE DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? 4 DEWEY DRIVE KIMBROUGH ARMY HOSPITAL NO P YES NAME OF 4 DATE Lost Month Year DECEASED (Type or print) Frank XXIII EXILATELY T. KINACKEX MARCH 19 67 WANAT DEATH JE UNDER 1 YEAR IF LINDER 24 HRS 6. COLOR OR RACE B. DATE OF BIRTH 9. AGF (In years removè ( 7 MARRIED **NEVER MARRIED** lost birthday) Months Dovs Hours WHITTE DIVORCED 13 MARCH 1920 MALE 10a JSUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State or foreign country) 12. CITIZEN OF WHAT lease, attending physicion termit. Then please GARWOOD, NEW JERSEY TVIL SERVICE ANALYST 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME or removal. ANNA KUFTA DMYTRO WANAT IS WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT 16. SOCIAL SECURITY NO. 4 Dewey Drive (Yes, no, or unknown) (If yes give wor or dates of service) Betty E. Wanat, Ellicott City, Md 154-01-5904 1B CAUSE OF DEATH (Enter only one couse per ne for (o), (b), and (c).) INTERVAL BETWEEN been signed by the as the bunal-transit prior to bunal, crematic PART | DEATH WAS CAUSED BY ONSET AND DEATH Severe Coronary Arteriosclerosis IMMEDIATE CAUSE (o) DHE TO Suspicious Acute Myocardial Infarction (Pending Conditions, if any, which gave rise to immediate cause (a), DUE TO stoting the underlying couse be detached for use as the State Dept. of Health prior to microscopic exam) lost PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BULL NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19 WAS AUTOPSY PERFORMED? YES 🗶 NO 200 ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 3B) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour am Not While foctory, street, office bldg , etc.) of work AFTENDING at work XX 24 MARCH, 19 67 that wixtonexton 21. I certify that HKNOXXINXONXIKONIA the deceased NOOK WAS DOA XX O HOSPITAL OR ATTENT Page 4 moy be retained O FUNERAL DIRECTOR: and that death accurred at 4:25 M, from causes and an the date stated above X9X 220. SKANATURE 22b DATE SIGNED ATTENDING MED DIRECTOR W 24 March 1967 PHYS 22d. ADDRESS JOHN M. ADAMS, CPT, MC KIMBROUGH ARMY HOSP, FT GEO G MEADE, MD NAME (Type) 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23b DATE THEREOF (County) BURIAL, CREMATION, REMOVAL (Specify) 29 1967 250 REC'D BY REGISTRAK 250 REGISTRAR S SIGNATURE VR A15 (4) 25M 1/67 Charles Ellicott City



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH death. funer and PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. CDUNTY b. COUNTY [.64JOCK hours after MARYLAND CITY DR TOWN (if outside corporate limits, write-RURAL and give nearest town) c. LENGTH DF STAY IN 1b c. CITY OR TOWN (Proutside corporate limits, write RURAL and give nearest town) physician and completely filled in by n please remove carbon papers. Pag val, and in any event, within 72 hours. Dallemen d. NAME OF HOSPITAL DR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE DN A FARM? ND 🔀 YES executed within NAME DE DECEASED 3. Middle DATE Day DF DEATH (Type or print) 19 SEX 6. CDLOR OR RACE AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS last birthday) | Months | Days | Hours | Min. DATE DE 7. MARRIED D 9. NEVER MARRIED YES 1Da. USUAL DCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR (County & State, or foreign country) 12. CITIZEN OF WHAT certificate be during most of working liter even if retired) INDUSTRY 76.5, a A-22 -blower removal, 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMANT Address After this certificate has been signed by the atten d be detached for use as the burial-transit permit. State Dept, of Health prior to burial, cremation, or i death (Yes, no, or unknown). (If yes give war or dates of service) were actioness 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: or attending physician. IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate DUE TO cause (a), stating underlying cause last as CERTIFICATION PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO 19. WAS AUTOPSY FDAOTHETERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? YES ND 😾 2Da. ACCIDENT WAS UNDERLYING I DESCRIBE HOW INJURY DCCURRED. (Enter nature of Injury in Part | or Part |) of Item 18.) OR CONTRIBUTING IT CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED 120e, PLACE OF INJURY (Home, farm, I (State) 2Df. (City or town) (County) factory, street, office bldg., etc.) Hour a.m. While Not While at work at work be retained ATTENDI TO FUNERAL DIRECTOR: A director, page 3 should should be filed with the 21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on and that death occurred at A.M. from the causes and on the date stated above 22a. SIGNATUR 22b. DATE SIGNED ATTENDING PHYS. STAFF PHYS. MED. DIRECTOR Page 4 may 1 M.D. PHYSICIAN'S ADDRESS 22d. NAME (Type) BURIAL, CREMATION.I 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) REMOVAL (Specify) MdA A Co Cedar Hill Bur a FUNERAL DIRECTOR REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles VR A15 (4) 196 DATE MA McCully F H 237 Patansco Ave 21 225 15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03119 CERTIFICATE OF DEATH and 2 The law requires that the death certificate be executed within 24 haurs after death funeral s 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY o. STATE b. COUNTY after MARYLAND Anne Arundel Anne Arundel Maryland c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b CITY OR TOWN (If outside corporate imits, CLENGTH OF STAY IN 16 write RURAL and give negrest town) RURAI- Severna Park 7% hrs. Annapolis d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) & STREET ADDRESS e. 15 RESIDENCE .⊑ ON A FARM filled YES NO A Anne Arundel General Hospital Rt#] Box 409 NAME OF Middle DATE First Month Year completely DECEASED 24 White Jr. (Type or print) George DEATH none E NEVER MARRIED IF UNDER 1 YEAR IF UNDER 24 HRS S SEX 6. COLOR OR RACE B. DATE OF BIRTH 9 AGE (In years 7 MARRIED renyave lost birthday) Months Doys Hours in ony WIDOWED DIVORCED 6-3-97 Negro Male and 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT 10o JSUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & State, or foreign country) COUNTRY? during most of working life, even if retired and 13. FATHER'S NAM ar removal, WAS DECEASED EVERIN U.S. ARMED FORCES? SOCIAL SECURITY NO 17 INFORMANT transit permit. (Yes no, or unknown) [If yes give wor or dates of service] CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c)
PART 1 DEATH WAS CAUSED BY. INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (o), DUE TO stoting the underlying couse lost WAS AUTOPS hds PART 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) PERFORMED? NO centificate ATTENDING PHYSICIAN: 20b DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of Item 18) 206 ACCIDENT WAS JNDERLYING [ OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MED CAL 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, farm, (City or town) (County) (Stote) 2Dc TIME OF IN-JRY Month, Doy, Year Heur To.m. foctory, street, office bldg., etc.) While Not While 19 of work of work \_\_1967\_, and that death occurred at 7:00 M, from causes and on the date stated above sow the deceased alive on March 24 TO FUNERAL DIRECTOR: 220 SIBNATURE 22b DATE SIGNED director, page 3 should be filed v M.D DIRECTOR PHYS PHYS. 22- PHYSICIAN'S 22d ADDRESS O HOSPITAL NAME (Type) 373 Franklin St. Annapolis, Maryland Edward S. Beck BURLAN CREMATION direct NAME OF CEMETERY OR CREMATORY REMOVAL (Specify) 4. FUNERAL DIRECTOR A2So, REC'D BY REGISTRAR

A Tomas Pri

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03120 CERTIFICATE OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where deceosed lived, if institut on Residence before admission) o. COUNTY b. COUNTY o STATE MARYLAND OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after (If outside corporate limits. € LENGTH OF STAY IN 1b autside corporate limits, write RURAL and give nearest town) rite RJRAL and give neglest town)

WWAPOLIS Ē de NAME OF BOSPITAL OR INSTITUTION (If not up hospital, give street address) e. IS RESIDENCE ON A FARM? d STREET ADDRESS hin 72 filled YES NAME OF Middle Lost DATE Year corbon completely Doy DECEASED (Type or print) OF DEATH Wells WHITE George 6 COLOR OR RACE 7 MARRIED NEVER MARRIED DATE OF BIRTH 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 HR Jash birthdoy) Months Doys Hours WIDOWED DIVORCED and in ony 10o, US JAL OCCUPATION (Give kind of work done 1Db KIND OF BUSINESS OR 12. CITIZEN OF WHAT during most of working the even if retired) INDUSTRY COUNTRY? the attending physician sit permit. Then please 13 FATHERS NAME or removol. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO INFORMAN (Yes, pay or unknown) (If yes give wor or dates of service) B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c) PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN signed by the burial-tronsit **QNSET AND DEATH** IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove (b) rise to immediate couse (o), DUE TO tor use as the t Health prior to b stating the underlying couse this certificate hos been PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) WAS AUTOPSY PERFORMED? NO I 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of Item 18) 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING I CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER! 2Dc TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 2De PLACE OF INJURY (Home, form (City or town) (County) (Stote) Hour o.m. foctory, street, office bldg., etc.) Not While ot work ot work 1967, that (I) (we) las 21. I certify that (1) (this haspital) attended the deceased from TO FUNERAL DIRECTOR: saw the deceased alive an\_ and that death occurred at 9 26 1965 P. M. fram causes and an the date stated above 22o SIGNATURE 22b DATE SIGNED DIRECTOR M.D. PHYS PHYS director, page should be filed ADDRESS 22c PHYSICIAN TO HOSPITAL NAME (Type NAME OF COMETERY OR CREMATOR) FUNERAL DIRECTOR **ADDRESS** 

**Q** 

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03121 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after deoth 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before damission) PLACE OF DEATH h COUNTY o. COUNTY a. STATE Anne Arundel MARYLAND Maryland c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b CITY OR TOWN (If outs de corporate limits, write RURAL and give nearest town) r LENGTH OF STAY IN 16 Crownsville Severn 10 days e IS RESIDENCE ON A FARM? d. NAME OF HOSP TAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS YES TX NO [ Crownsville State Hospital Box 99B Rt. #3 4 DATE carbon ent, with NAME OF Middle Lost Month Doy Year DECEASED (Type or print) #34017 Whites DEATH 19 07 Lora IF LINDER 24 HRS 9 AGE (In years IF UNDER 1 YEAR B. DATE OF BIRTH S SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED signed by the attenling physician ond com buriol-transit permit. Then please removel buriol, cremation, or removal, ond in any ev last birthdoy) Months Doys Hours WIDOWED DIVORCED 1/22/1887 Female. White 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 12. CITIZEN OF WHAT TOB KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) COUNTRY? INDUSTRY Kentucky
14. MOTHER'S MAIDEN NAME IISA Inemployed

13. FATHER'S NAME Stidmam Harve Dills TS WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) ((If yes give wor or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address 254-40-0367 Hospital Records INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c))
PART I. DEATH WAS CAUSED BY:
Programs ONSET AND DEATH Pneumonia signed by 1 buriol-trans IMMEDIATE CAUSE (6) DUE TO Conditions, if ony, which gove ) Cardio-Vascular Accident rise to immediate cause (a). DUE TO stoting the underlying couse be detached far use as the State Dept. of Health prior to 19. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO X Chronic Brain Syndrome due to Senility TO FUNERAL DIRECTOR: After this certificate director, page 3 should be detached far us should be filed with the State Dept. of Healt PHYSICIAN: 205 DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.) 20a, ACCIDENT WAS UNDERLYING Page 4 may be retoined by the hospital OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (County) (Stote) TIME OF INJURY Month, Doy, Year 2Dd. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) foctory, street, office bidg., etc.) Not While at work at work 3/18/ , 19\_67, ta 3/27/\_\_\_, 1967, that (I) (we) last 21. I certify that (I) (this haspital) attended the deceased fram. 3/27/619 67, and that death accurred at 3:30 M, fram causes and an the date stated above. saw the deceased alive long 22b DATE SIGNED 220 SIGNATURE 3/28/67 M,D PHYS. DIRECTOR PHYS 22d ADDRESS 22c. PHYSICIAN'S NAME (Type) Crownsville State Hospital Maryland Jonel McHenry Mann 23d LOCATION (City or Town) 23c. NAME OF CEMETERY OR CREMATORY 23b DATE THEREOF (County) (Stote) 23o. BURIAL, CREMATION, REMOVAL (Specify)
Burial Md. Glen Haven Memorial Glen Burnie 30 March 67 250 REC'D BY REGISTRAR 25h REGISTRAR S SIGNATURE 24 FUNERAL DIRECTOR MAR 30 1967 VR A15 (4) 20 M 1/66 Kirkley Funeral Home. Glen Burnie . Md.



PRESTON STREET, BALTIMORE 1, MARYLAND **DIVISION OF STATISTICAL RESEARCH AND RECOR** DEATH OF PLACE OF DEATH 2. USUAL RESIDENCE (Where decassed lived, if institution: Residence bafora edmission) COUNTY 5. COUNTS MARYLAND L CITY OR TOWN c. LENGTH OF STAY IN 16 CITY OR TOWN Is outside corporate limits, write outsida corporate limits. Write RURAL and give nearest fown! Pages d. STREET ADDRESS ON A FARM? completely papers. n 72 hoi YES NO NAME OF DECEASED (Type or print) DATE 4, Month Dev Year OF DEATH carbon nt, within IF UNDER 24 HRS and DATE OF BIRTH 9. AGE (In years | IF UNDER 1 YEAR NEVER MARRIED 7. MARRIED last birthday) Months | Deys Hours WIDOWED [ DIVORCED physician remove USUAL OCCUPATION (Give land of work during most of working life, wan if railrad) 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY or foreign country) wenn an attending pt Then please C 13. FATHER'S NAME MOTHER'S MAJOEN NAME and Then 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16, SOCIAL SECURITY NO. | 17. INFORMANT (Yas, no, or unkown), (If yes givewer or dates of service) permit. Š 18. CAUSE OF DEATH [Enter only one couse p INTERVAL BETWEEN ò OMSET AND DEAD PART I. DEATH WAS CAUSED BY: signed IMMEDIATE CAUSE (a cremation, burial-fransit Conditions, if env. which (b) gave rise to immediate cause DUE TO (a), steting the underlying cause lest. certificate PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUYNOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a), 19. WAS AUTOPSY Se 2 CERTIFICATION PERFORMED? USe prior NO [ YES 2Da, ACCIDENT WAS UNDERLYING 206. DESCRIBE HOW INJURY OCCURRED. (Entar nature of injury in Pert I or Pert II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH Health detached WEDICAL 20d. INJURY OCCURRED 2De, PLACE OF INJURY (Home, farm, ! 2Df. (City or town) (County) (State) 2Dc. TIME OF INJURY Month, Dey, Year ö factory, streat, office bldg., atc.) While Not While Hour e.m. DIRECTOR: et work e! work D.00. å shoul 22b. DATE 22a. SIGNAZURE ATTENDING SIGNED HOSPITAL. DIRECTOR PHYS. FUNERAL page M.D. PHYS. Page 22d. ADDRESS 22c. PHYSICIAN'S TO FUNE director, be filed NAME (Type) 23e. BURIAL, CREMATION, | 23b LOCATION (City, town or (State) 23c. NAME OF CEMETERY OR CREMATORY REMOVAL (Specify) REC'D BY REGISTRAR **ADDRESS** 25b VR A1S (4) 20M 5-63



| À 1   | MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |
|---|--|--|--|--|
| FOR STATE   | 03123  | MEDICAL EXAMINER'S CERTIFICA                                 |  | 03114                                  |
| HEALTH DEPT.  | 1. PLACE OF DEATH O. COUNTY P. M. CO   | MARYLAND O. STATE  | 7-7 3  | AACO.                                  |
| th If Cry delay is ges 1, 2, and 3 to a farm PM3. Page ate Department of hours after death.   | b CITY OR TOWN (If autside corporate limits, white RURAL and give begress (30%))  d. NAME OF HOSPITAL OR INSTITUTION ( † not in  |  | N (If outs de corporate limits, write RURAL o<br>RNA - FARK -<br>ESS | 2:1                                    |
| ges 1, form form form   | D.O.A NORTH AR   |  | B0x618   | e IS RES DENCE<br>ON A FARM?<br>YES NO |
| Par Par Vith Vith Vith Vith Vith Vith Vith Vith   | 3 NAME OF DECEASED (Type or pnnt)  | J. Middle Lost St.   |  |  |
| urs after d<br>18. Give<br>ce olong v<br>12 with the<br>nt within   | MW   | MARRIED NEVER MARRIED B DATE OF BIRTH WIDOWED DIVORCED 3-7-4 | 2. tost pirthdoy) Mo   | UNDER 1 YEAR IF UNDER 24 MRS           |
|   |  |  |  |  |
| v thin pence compage (opping le pogie) id in o  | 13 FATHER S NAME  Robert Wise  | 14 MOTHERS M   | a den name<br>Bridge   |  |
| The social security no 115 WAS DECEASED EVER No. S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Address  |  |  |  | Route 2                                |
| ertificate should be executed writing the word "pending" in rworded to the Chief Medical E sed as a buriol-transit permit. F surial, cremation, or removal, a | IB. CAUSE OF DEATH (Enter only one couse PART I DEATH WAS CAUSED BY.  IMMEDIATE CAUSE (o)  OUE TO  Conditions, if only, which gave its to immediate cause (o), stating the underlying couse lost   |  |  | INTERVAL BETWEEN ONSET AND DEATH       |
| 0 . 5 5 2 0   | lost   (c)   PART II OTHER SIGN-FICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)   The part is of the part in th   |  |  | 19 WAS AUTOPSY PERFORMED? YES NO       |
| AMINER: This e the certificate, a 4 should be four files. ge 3 should be u ge 3 should be u ogent, prior to   | PRIMARY CONTRIBUTING CAUSE OF DEATH  | 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of in         | eito Car   |  |
| MIN<br>the<br>4 sh<br>Ur fil  | 20c TIME OF INJURY Month, Doy, Yeor Hoor om 3 -4 196   | 0 HUIZ - 1747 4  | dg., etc.)   | (Caunty) (State)                       |
| TA Sixe   | death resulted from Natural (  |  | , Inspection , Inquiry micide , Undetermined manne                   | and in my opinion                      |
|   | ACTUAL SIGNATURE Turbucks  EXAMINER'S  | M.D ASSISTAL   | NT MEDICAL EXAMINER  | 22. DATE SIGNED                        |
| O DEPUTY necessary, the funero s may be o FUNERAL   | PARTITION STATE THE TENTON STATE THE TEN | F 23c NAME OF CEMETERY OR CREMATORY                          | (Street, city, town, or county)  23d. LOCAT ON (City or Town)        | 3-4-67<br>(County) (State)             |
| E 12  | REMOVAL (Specify) 3-8-1967 24 FUNERAL DIRECTOR   |  | Baltimore, Mar   | Yland<br>TARS SIGNATURE                |
| VR A15ME (3)  | Lilly & Zeiler Inc.  |  |  | Charles Judge                          |



| \$1 X 1  | MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |
|--|--|--|--|--|
| FOR STATE/   | 0040:  | CERTIFICATE OF DEATH   |  |  |
| HEALTH DEPT.   | I. PLACE OF DEATH  O. COUNTY ANNE ARTINDEL  MARYLAND   | 2. USUAL RESIDENCE (Where deceosed lived, if instituted Residence before admission) o. STATE WALLY AND b. COUNTY A. A.   |  |  |
| f any delay is 1, 2, and 3 to m PM3. Page Department of a after death.   | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |  |  |
| E E OS OR  | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress)  OF IN HOSPITAT.  | d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES NO   |  |  |
| hours after death. If<br>Item 18. Give Poges<br>Office along with fall<br>I ond 2 with the Stern<br>event within 72 hour   | (i) be or pinn)  | W.DOD Lost 4. DATE Month Doy Year OF DEATH PIARCH 18 19 67   |  |  |
| hours after deat<br>Item 18. Give Poc<br>Office along with<br>Iond 2 with the St   | S. SEX  MAIN  6. COLOR OR RACE  7. MARRIED  WIDOWED  DIVORCED  DIVORCED  | 9/16/18 1898 9. AGE (In yeors lost birthdoy) 68 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Doys Hours Min.   |  |  |
| r's r's  | 100. USUAL OCCUPATION (Give kind of work done during not of working life even if retired)  13. FATHER'S NAME  13. FATHER'S NAME  | Duwkirk MD. 12. CITIZEN OF WHAT COUNTRY S. A.  |  |  |
| d be executed within 24 d "pending" in pencil in Chief Medicol Examiner's transit permit. File pages , or removal, and in ony  | JOHN WOOD  | 14. MOTHER'S MAIDEN NAME MARKQUESS INFORMANT Address   |  |  |
| be executed<br>"pending" in<br>hief Medicol<br>ansit permit.<br>or removal,  | (Yes go or unknown) (If yes give wor at dotes of service) 200 09 4214  | BOSIE L. WOOD #2   |  |  |
| should be e.<br>ne word "pen<br>ta the Chief M<br>buriol-transit  <br>motion, or rer   | PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a)  PULMONARY HEMORRHA  |  |  |  |
| This certificate should be executed within cote, writing the word "pending" in pencil be forwarded to the Chief Medical Examine. be used as a burial-transit permit. File page it to burial, cremation, or removal, and in a | Conditions, if ony, which gove rise to immediate couse (o), stoting the underlying couse   | SEVERAL MO.  |  |  |
| s certificate slaw, writing the forwarded to used os a burial, cremo   | OST.   (c)   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO  | PERFORMED?   |  |  |
| <del>4</del> 200   | 2Do. EXTERNAL CAUSE WAS   20b. DESCRIBE HOW INJURY OCCURRED.   CAUSE OF DEATH   NO INJURY  | (Enter nature of injury in Part I or Part II of item 18.)  |  |  |
| INE<br>shou<br>files<br>3 shou   | S 2Dc. TIME OF INJURY Month, Doy, Year 2Dd. INJURY OCCURRED 2De. PL.   | ACE OF INJURY (Home, form, ctory, street, office bldg., etc.)  2Df. (City or town) (County) (State)  |  |  |
| brcal Exam<br>se execute th<br>ector. Page 4<br>ned for your<br>ECTOR: Poge<br>ssignoted age   | 21. I certify that I taak charge af the remains described above, held an Autopsy , Inspection , Inquiry , and in my apinion death resulted from: Natural causes , Accident , Suicide , Hamicide , Undetermined manner  |  |  |  |
|  | ACTUAL MONIES WINTE MIN  | CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINE |  |  |
| TO DEPUTY MEDICAL EXAM necessary, please execute the funeral director. Page 4 5 may be retained for your TO FUNERAL DIRECTOR: Page Health or its designoted age  | EXAMINER'S CHARLES H. WIRTH, M.D.  230. BURIAL CREMATION, 23b. DATE THEREOF. 23G. NAME OF CEMELERY OR  | DEPUTY MEDICAL EXAMINER Address (Street, city, town, or county) LOT HTAN MD.  CREMATORY 23d. LOCATION (City or Town) (Jounty) (State)  |  |  |
| 5 = # 2 = *  | BREMOWAL Specific Commercial State Inference 235 Name of Commercial Office Commercial Co | M. Zion H. H. Zion H. H. Zion Zion By Registrar 25b. Registrar's Signature   |  |  |
| VR A15MENS   | John M. Ja Yort Sow Chruspolis, M  | a. DAMAR 21 1967 yellerles Judge   |  |  |

Jilga3 Cirk SERVICE DRUKLEK, MD. RiggER JOHN WOOD LILLIE MARKOUESS YES WELL SOO CHAM POSIE L WOOD

BERTAL 3-81-67 At Zion HA Zion HA HE

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 83125 deoth. requires that the death certificate be executed within 24 hours ofter death physicion and campletely filled in by the funeral I. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) o. COUNTY o. STATE b. COUNTY Anne Arundel MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest fawn)

Annapolls c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town) hours Washington IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS within 72 Bay Manor Nursing Home 1901 3rd. Street. N.W. YES NO T 3. NAME OF First Middle Lost 4. DATE Day Year DECEASED CLARENCE K. WORMLEY 1967 (Type or print) DEATH IF UNDER I YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 7. MARRIED DATE OF BIRTH 9. AGE (In years **NEVER MARRIED** lost birthdoy) Months Days Hours 1/8/1875 Male Negro WIDOWED DIVORCED 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) olease ama ii during most of working life, even if refired) COUNTRY? INDUSTRY Washington, D.C. 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME ottending phys nermit. Then p remova James T. Wormley Mary Ringold IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT 1901 3rd. Street. N.W (Yes, no, or unknown) (If yes give wor or dates of service) 0 Gertrude D. Wormley Washington, D.C. cremotion, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line far (o), (b), opd (c).) burial-transit AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) signed by physicion. DUE TO burial Conditions, if any, which gave rise to immediate couse (a), DUE TO attending ; stating the underlying couse FUNERAL DIRECTOR: After this certificate has been use os the prior to 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO X be retained by the hospitol or for 20o. ACCIDENT WAS UNDERLYING [ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year Not While foctory, street, office bldg., etc.) 19 at work pe 1965 1967, that (1) (we) last 21. I certify that (i) (this hospital) attended the deceased fram ta 1967, and that death accurred at 10:50 PM, fram causes and an the date stated above saw the deceased alive an 22b. DATE SIGNED 220 SIGNATURE ATTENDING PHYS. Z DIRECTOR PHYS 22d. ADDRESS PHYSICIAN'S NAME (Type) director, should be 23o. BURIAL, CREMATION, 23b. DATE THEREOI 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) Landover, Maryland Harmony 0 25b REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR 25o. REC'D BY REGISTRAR VR A15 (4) 20 M 1/66 You Street. N.W. Mianley & Jarvis Co.

31150 DATE OF PARTY OF THE PART 4.5 Abne America Acceptant They burds Murriane Hope . Should stone Strong fally HANTA A SARRADA = 1/8ABIS al. T. godyszanan biosnil yan Nothern W. Section Carterels D. Veteley unedateten, D.D. A STATE OF THE PARTY OF THE PAR The Manual Very and Amelot I I was the ter the term to the term of th to the second second The same that the first the State to elrent beams w